

Aspects of culture in South African psychiatry

Leslie Swartz

DIGITISED

23 JUN 2015

**A dissertation submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy**

Department of Psychology

University of Cape Town

1989

The University of Cape Town has been given the right to reproduce this thesis in whole or in part. Copyright is held by the author.

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

Abstract

A review of the South African psychiatric literature reveals that the concept of culture is commonly reified. It is also used by the South African state to legitimate apartheid.

The concept of cultural relativism, though often associated with liberal views internationally, is linked with state policies in South Africa. Some South African social scientists, therefore, strongly question the notion of relativism. This reaction unfortunately does not engage with the social reality of the widespread perception of cultural differences, in psychiatric settings and elsewhere.

Issues of race and culture in psychiatric practice were explored in a psychiatry department of a liberal South African university. Observation of ward-rounds in a psychiatric casualty (emergency) facility over six months revealed that, as elsewhere in the world, a major cultural factor influencing clinicians is the relationship between psychiatry and general medicine. A cultural understanding of South African psychiatry must take account of this relationship.

Ward-rounds in a facility treating Black psychiatric patients were observed over fifteen months. Black and white clinicians in these rounds were often in conflict over constructions of the concept of culture. Some appeared deeply ambivalent about cultural relativism.

Psychiatric registrars (residents) attached to the department under study participated in loosely structured interviews exploring issues of race and culture in their work. They also responded to vignettes dealing with white, coloured and Black patients. Registrars felt uncomfortable about the role of the concept of cultural difference in affecting the welfare of Black patients, and in maintaining discrimination. Their own socialisation as

practitioners in an individualising and medicalising discipline seems a major factor contributing to their ongoing reproduction of this discrimination.

The study reveals the importance of exploring the views and experiences of practitioners. South African work focussing on the need for fundamental change in mental health care has generally glossed over details of extant practice. This dissertation shows, however, that a major site for mobilisation for change in South African mental health care must be the psychiatric institution itself.

Acknowledgements

I should like to thank a number of people and organisations.

My supervisor, Assoc Prof Don Foster, was a constant source of encouragement, enthusiasm, and constructive suggestions. In spite of being very busy, he always made the time to give me prompt and full comments on my work.

Sally Swartz has been more of a help to me during the years I have been working on this project than I can begin to record. She has read and commented on earlier versions of material presented here, and was the source of many lively discussions and useful insights. Most of all, I am grateful to her for encouraging me to take pride in my work.

Dr Tim Dunne of the Department of Mathematical Statistics suggested the method of data presentation I use in Chapter 11, and provided helpful comments on methodology.

Mrs P provided me with a quiet and pleasant place to write up the dissertation. Without it I should probably still be writing.

Bev Dickman, Pete Hodson, Ann Levett, Tracey Miller, Didi Moyle, Jennie Pilkington and Joan Westaway all put themselves out to help me with this project.

Pat Boulton, Sue Cooper, June Coutts, Gerard Drennan, Karin Fischer-Buder, Rebecca Goldberg, Debra Korber, Lisa Levy and Eleanor Stipinovitch provided typing and research assistance over the years.

The head of the department of psychiatry in which this study was undertaken, the ethics committee of the university's medical faculty, and the medical superintendents of the hospitals concerned gave the necessary permission for me to undertake the study. I am particularly grateful to ward-round participants and to the registrars I interviewed for their openness and their help.

Colleagues, friends and students have all contributed to the ideas presented in this dissertation. The responsibility for the final product, however, is mine alone. The dissertation does not reflect the views of any other person or organisation.

The Research Committee of the University of Cape Town, the Centre for African Studies and the Mellon Foundation provided financial assistance.

Alison and Rebecca performed the important service of ensuring that I keep my work in perspective.

TABLE OF CONTENTS

Abstract	i
Acknowledgements	iii
List of tables	xvi

Chapter 1	Preface	1
I.	Introduction	2
II.	Traditions in research into culture and psychiatry	3
III.	Psychiatry and the problem of culture in South Africa	6
IV.	Outline of organisation and methods in the dissertation	7
	A. Organisation of the dissertation	7
	B. A note on theory and methods	8
	Notes	10

Part 1:

Situating South African Transcultural Psychiatry

Chapter 2	An overview of recent South African transcultural psychiatric literature	12
I.	Introduction	13
A.	Theoretical background	13
B.	Terms and scope	15
II.	Mental health, psychopathology, and healing	16
A.	Contexts for interpreting mental health and illness	16
1.	Personality, world-view and attitudes	17
2.	The social context	22
3.	Psychological theories	24
B.	Indigenous illnesses	26
C.	Indigenous healing	29
1.	Approaches to understanding and evaluation of indigenous healing	31
2.	Problems integrating indigenous healing and biomedicine	34
III.	Cross-cultural issues in mental health practice	35
A.	Diagnosis and epidemiology	36
B.	Cross-cultural aspects of psychotherapy and counselling	42
IV.	Cross-cultural studies on anxiety and stress	46
A.	Issues in the theory and methodology of cross-cultural stress research	46
B.	Stress, alcoholism and psychosomatic disorder	49
1.	Alcoholism	49
2.	Hypertension	50

3.	Duodenal ulceration and gastrointestinal problems	51
4.	Coronary heart disease	52
V.	Concluding comments	53
	Notes	55

Chapter 3 Apartheid and mental health 57

I.	Introduction	58
II.	Apartheid and mental health care	59
	A. Health care policy and practice in South Africa	59
	B. Mental health services	62
III.	Does apartheid cause mental illness? ,	66
IV.	Apartheid and the production of knowledge about mental health	71
V.	The South African psychiatrist in relation to apartheid	74
	A. Descriptions of apartheid psychiatry and psychiatrists	74
	B. Professional and alternative organisations	77
VI.	Concluding comments	80
	Notes	82

Chapter 4 The question of relativism in South African psychiatry 80

I.	Introduction	81
II.	Complementarism and relativism in ethnopsychiatric theory ,	82
	A. Devereux's complementarism	82

B.	Cultural relativism	84
III.	The language of 'relativism' in South Africa - a strategy for domination	87
IV.	Redefining culture in South Africa: the problem	89
V.	The production of psychiatric knowledge in South Africa	93
A.	Producing 'otherness' in a universalist context	95
1.	Finding otherness amidst diagnostic similarity	96
2.	Ascribing 'compliance problems' to otherness	97
VI.	Clinical practice and the search for appropriate models of explanation	100
VII.	Implications and conclusions	106
	Notes	108

Part 2: Psychiatric ward-rounds

Chapter 5	Introduction to Part 2: the study of psychiatric ward-rounds	110
I.	Background information	111
II.	The study of psychiatric ward-rounds	112
A.	Theoretical background	112
1.	The macrosocial approach	112
2.	The microsocial approach	113
3.	Combining microsocial and macrosocial levels	116
B.	The psychiatric ward-round	120

III. Method	123
A. Settings	123
B. Data recording	124
C. My role in the ward-rounds	124
D. Selection of material for presentation and analysis in the dissertation	125
Notes	127

Chapter 6 Ward-rounds in a psychiatric casualty unit 130

I. A description of PC and PC ward-rounds	131
II. PC and medical marginality	133
III. Talk about 'race' in PC	136
A. The relevance (or otherwise) of race and culture to PC	139
IV. Concluding comments	141
Notes	144

Chapter 7 Ward-rounds on the 'Black side' of Eagle's Nest Psychiatric Hospital 146

I. A description of the 'Black side' and the Black side ward-rounds	147
II. Ritualised aspects of ward-rounds	151
III. Issues arising out of the rounds	153
A. Multiplicity of interpretation	153
B. The politics of interpretation	159
C. The politics of culture	163

1.	Which culture?	163
2.	'Culture' as a site of conflict	165
3.	'Culture' as a source of power and resistance	168
IV.	Concluding comments	172
A.	Biomedicine, psychiatry, and the production of cultural identity	173
	Notes	176

Part 3: Interviews with psychiatric registrars

Chapter 8	Introduction to Part 3: interviews with psychiatric registrars	181
I.	Broad aims	182
II.	The focus on psychiatric registrars	184
A.	Why practitioners of the discipline of psychiatry?	184
B.	Why psychiatric registrars?	185
III.	Theoretical background	188
A.	Paradigmatic tensions in psychology and cross-cultural psychiatry	188
1.	'Old' and 'new' paradigms in psychology	188
	a) An important methodological rider of the 'new' paradigm	191
	b) An important theoretical feature of the 'new' paradigm	193
2.	New paradigms in medical anthropology and cross-cultural psychiatry: some parallels with new paradigms in psychology	195
B.	Organisational ethnography and the study of professionalism	196
IV.	Method	197

A.	The registrars	197
B.	Procedure	198
1.	Interview 1	199
2.	Interview 2	200
C.	Materials: the vignettes	205
1.	The vignette of Mr A	210
2.	The vignette of Mr M	211
3.	The vignette of Mr X	212
4.	The choice of suburb names	213
D.	Data analysis and presentation of results and discussion	214
	Notes	216

Chapter 9 Registrars' reports on patients from different backgrounds 222

I.	Introduction	222
II.	Diagnosis	222
A.	The diagnosis of Mr A	224
B.	The diagnosis of Mr M	224
1.	Diagnosing Mr M as depressed	225
C.	The diagnosis of Mr X	229
III.	Special issues in diagnosis and aetiology	230
A.	Talk of toxins and the diagnosis of toxic psychosis	230
B.	Talk of 'culture' and the diagnosis of 'culture -bound syndromes'	239
1.	Cultural dislocation as implicit pathogen	247
IV.	'Stress', family relationships, psychodynamics and the causation of psychopathology	247

V. Concluding comments	253
Notes	255

Chapter 10 Registrars' talk about psychiatric services, culture, and race 257

I. Introduction	258
II. Care of the patients mentioned in vignettes	258
A. Patterns of care and racial segregation	258
B. Pressure on services and unpleasantness of facilities	260
C. Containment, care and control	264
III. The prospect of integration of services by race	270
IV. Registrars' talk about other issues concerning race and psychiatric services.	279
V. Concluding comments	283
Notes	284

Chapter 11 Registrars' ranking of vignettes 286

I. Introduction	287
II. Method of analysis	289
III. Results and discussion	292
A. Certainty of diagnosis	292
B. Adequacy of care available	294
C. Prognosis	296

D.	Personal preference for working with patients	298
E.	Registrars' assessments of their own clinical effectiveness with patients	300
IV.	Concluding comments	302
	Notes	304

Chapter 12 Professional issues in registrar training and their relationship to questions of race 305

I.	Introduction	306
II.	The training of registrars and their own psychiatrisation	306
III.	Broader issues of individualisation	310
IV.	The individualised registrar and the issue of race	312
V.	Concluding comments	316
	Notes	318

Part 4: Conclusion and postscript

Chapter 13 Conclusion 321

I.	Issues arising from the dissertation	322
II.	Current and future issues for mobilisation in South African psychiatry	328
III.	Summary and concluding comments	337

Chapter 14	The state, resistance, and the emotions in South Africa: notes towards a theory	342
I.	Introduction	343
II.	The development of alternative mental health services in South Africa	343
A.	Alternative services as messages to the state and the outside world	345
B.	Alternative services as messages to progressive people and organisations	346
III.	Implications and conclusions	347
	Notes	350

References	351
-------------------	------------

Appendices

Appendix A	A brief outline of units in the hospital system	390
Appendix B	Previous and current placements of registrars at the time of the study	393
Appendix C	Text of letter sent to psychiatric registrars	398
Appendix D	Key to Present State Examination symptoms and syndromes used in the construction of the vignette studies in Part 3 of the dissertation	399
Appendix E	Complete tables for registrars' ranking of vignettes	402

LIST OF TABLES

Table 9.1	Primary diagnoses for the vignettes	223
Table 9.2	Diagnoses (primary and differential) of toxic psychosis by vignette and race	230
Table 9.3	Diagnoses of toxic psychosis (primary and differential) by area, collapsed across vignette type, and excluding the diagnoses of Dr 15	231
Table 9.4	Mention of cannabis and/or methaqualone in any or all of the 'diagnosis', 'aetiology', or 'other information' categories by area, collapsed across vignette type, and excluding the responses of Dr 15	233
Table 9.5	Mention of drugs by category and race, collapsing across vignettes, and excluding the responses of Dr 15	234
Table 9.6	Two-way table showing mention of 'toxins' and 'culture' as diagnostic category (primary or differential) or aetiological agents in discussion of Black patients. (excluding the responses of Dr 15)	235
Table 10.1	First and second placements of registrars, ranked by frequency	280
Table 11.0	Ranking of vignettes on the dimension of certainty of diagnosis	289
Table 11.1	Summary matrix showing total rankings of vignettes on the dimension of certainty of diagnosis	292

Table 11.2	Summary matrix showing total rankings of vignettes on the adequacy of care available	294
Table 11.3	Summary matrix showing total rankings of vignettes on prognosis	297
Table 11.4	Summary matrix showing total rankings of vignettes on registrars' preference for working with the patients	299
Table 11.5	Summary matrix showing total rankings of vignettes on registrars' assessments of their own effectiveness in treating patients	300

Chapter 1

Preface

Table of contents

I.	Introduction	2
II.	Traditions in research into culture and psychiatry	3
III.	Psychiatry and the problem of culture in South Africa	6
IV.	Outline of organisation and methods in the dissertation	7
A.	Organisation of the dissertation	7
B.	A note on theory and methods	8
	Notes	10

Chapter 1

Preface

I. Introduction

This dissertation explores issues of culture in South African psychiatric theory and in aspects of practice. It focusses on practice in a psychiatry department attached to a liberal South African university. This university is committed to non-racialism and is opposed to apartheid.

Epidemiological information on psychopathology in South Africa, particularly amongst black people is, as will be seen in Chapter 2, sketchy and often of dubious quality. Given this fact, it may appear that the only serious agenda for any extended study of relationships between culture and psychiatry in this country must lie in the field of the elucidation of manifestations of distress and healing amongst black South Africans. Such research is indeed necessary. This dissertation, though, may be read as a refutation of the view that the study of culture in South African psychiatry is synonymous with the study of black patients - people of different backgrounds from South African psychiatrists, most of whom are white, middle class and male. I hope to show here that a primary issue on the agenda of South African psychiatry should be not only a careful exploration of what different patients look like but also a critical and reflexive examination of the very construction of the notion of cultural difference in South African psychiatry. This construction, as I shall show, has profound implications for clinical training and practice, both of which are embedded in the broader sociopolitical environment.

In taking up this position at the outset, I am aligning myself with a local political agenda - the push towards the creation of a non-racial democratic South Africa with health and mental health services equally accessible to all in terms of proximity, cost, and social

appropriateness. At the same time I am situating my own work in the context of particular traditions of psychiatric research concerned with issues of culture. By way of background, some features of different traditions in exploring questions of culture in psychiatry will be briefly outlined.

II. Traditions in research into culture and psychiatry

In consecutive years at the beginning of the 1980s, two books were published by British psychiatrists interested in relationships between culture and mental health. The first of these, by Leff (1981), was entitled *Psychiatry around the globe: a transcultural view*, and the second, by Littlewood and Lipsedge (1982), was *Aliens and alienists: ethnic minorities and psychiatry*. Both texts are currently into their second editions (Leff, 1988; Littlewood & Lipsedge, 1989). A major difference between the two books can be discerned simply from an examination of the titles. Leff is concerned with looking 'around the globe' at a range of manifestations of distress, and his book reads to an extent like a travelogue. Littlewood and Lipsedge, by contrast, foreground the notion of the 'alien' in their title, and focus very clearly on psychiatrists (or alienists) themselves.

The difference in emphasis between these two books is not trivial or, indeed, merely academic in the narrow sense of the term. In a brief review of Littlewood and Lipsedge (1982), Leff (1982) dismisses their approach for setting up British psychiatry as, as he puts it, an 'Aunt Sally' (p. 677). The editor of *Transcultural Psychiatric Research Review*, Prince (1983), by contrast, though not entirely unsympathetic to some of what Leff (1981) has to say, concludes his review of Leff's book with the damning comment that 'those interested in transcultural psychiatry would be advised to look elsewhere' (p. 118). Apart from anything else, the two books differ in orientation towards questions concerning the ideological position of psychiatry as a discipline in Britain and elsewhere¹ (footnotes appear at the end of each chapter).

Chapter 1: Preface

In both editions of his book, Leff (1981, 1988) implicitly dubs himself a cultural relativist, 'concerned to stress the concept of cultural relativity and to avoid an ethnocentric stance' (Leff, 1988, p. 211). It remains true to say, however, that despite some changes in the second edition, Leff's primary stance is that of a universalist². He clearly subscribes, furthermore, to the view that with modifications of a technical nature, it is possible to use standard psychiatric instruments to observe and record actual differences and similarities between different groups of people. Littlewood and Lipsedge (1982, 1989), by contrast, use detailed case description and an ethnographic approach to demonstrate the complexity of the stories of individual people and their relationship to broader social dynamics.

South African psychiatry is heavily influenced by British psychiatry. This is the case particularly but by no means exclusively in units attached to English-medium universities. In many such institutions, senior personnel are British-trained, and links with Britain maintained. The differences in approach in British psychiatry, however, are related to a broader debate - that between what Kleinman (1977) has termed the 'old transcultural psychiatry' and the 'new cross-cultural psychiatry'. According to Kleinman, proponents of the 'old transcultural psychiatry' (and Leff can be seen to represent an important tendency in this approach - the British empiricist psychiatry tradition) view western diagnostic categories as neutral and value-free entities, and engage in a quest for psychiatric universals. They cannot but 'find' these universals as their etic standard instruments can do nothing other than produce data constructed according to their own design - everything else is missed. The 'new cross-cultural psychiatry' works from a relativist perspective, explores texts of distress in qualitative detail, and attempts to elaborate meaning in a social context (Good, 1977; Good et al, 1982). Direct comparison of disorders across populations becomes far more complex both theoretically and technically, and there is great emphasis on being aware of the influence of what Kleinman has termed 'explanatory models' on the experience of distress and on the way that it is managed (Kleinman, 1980, 1986). Not only patients have 'explanatory models' - professionals do too, and an important goal of clinical

communication is the satisfactory negotiation between these models (Kleinman, Eisenberg, & Good, 1978).

I do not intend to review either the 'old transcultural psychiatry' or the 'new cross-cultural psychiatry' in any detail here³, and I have discussed elsewhere the implications of differences between the approaches for South African psychiatry (Swartz, 1984). What is central to the current discussion, however, is the observation that the 'new cross-cultural psychiatry' requires that theorists and clinicians constantly examine their own explanatory models and, indeed, their own role in the social and cultural construction of disorder and treatment (Eisenberg, 1988; Kleinman, 1983, 1987; Townsend, 1978)⁴. It is not surprising that a recent book by Kleinman on the psychiatry/culture interface is intimately concerned not simply with exploring differences between people of different backgrounds and in different circumstances but also with providing a cultural context for the understanding and transformation of psychiatric practice itself (Kleinman, 1988a). In the epilogue to the text, furthermore, Kleinman writes:

— To rethink psychiatry from a cross-cultural perspective...is to confront culture itself. How we think of culture will strongly influence how we configure the relationship between psychiatry and its cultural context.
(Kleinman, 1988a, p. 183).

In Kleinman's view, then, the task in rethinking psychiatry in cultural context, requires a rethinking not only of the culture of professional psychiatry, but a rethinking of the concept of culture itself. This dissertation will attempt to show that this requirement is particularly salient to an understanding of South African psychiatry.

III. Psychiatry and the problem of culture in South Africa

The situation of South African psychiatry is particularly interesting in relation to debates about culture in psychiatry internationally. Far from being blind to the issue of culture, South African psychiatrists and allied professionals, as will be seen throughout this dissertation, are constantly engaged in the production of ideas about culture in their academic work, in their clinical practice, and in the ways that they talk about themselves. The notion of cultural difference is pervasive. What is lacking in much South African work, however, is that aspect of the 'new cross-cultural psychiatry' which is self reflexive (Murphy, 1977; Hughes, 1989). South African transcultural psychiatry, quintessentially, is a corpus of knowledge and practice - what may be termed a discourse (Said, 1978; Young, 1987) - which constructs and maintains knowledge about members of 'other cultural groups' (blacks) without any examination of the process of construction itself. The concept of 'culture', as will be shown in Part 1 of this dissertation, is an important ideological tool in the legitimisation of oppressive practices on the part of the South African state. Used in an unproblematised way in South African psychiatry, as it tends to be, the very concept yokes psychiatric theory and practice to apartheid ideology and oppression.

I shall demonstrate that South African theorists and clinicians, regardless of their apparent affiliation for the 'old transcultural psychiatry' or for a more relativist approach, are in general united in their reproduction of apartheid concepts and practice. Many of them would claim that they are interested in the issue of culture because it is a reality - indeed, for many of the cogent reasons put forward by authors such as Kleinman (1988a). I have no reason to doubt the sincerity of such people, but I shall insist that without a decentering of received notions about culture (and these notions are not purely South African in origin or reproduction) it will not be possible to develop a South African psychiatry which is truly equitable and accessible to all. It is this belief which has lead me to explore in this dissertation not the 'cultures' of black South Africans, but aspects of South African professional psychiatric culture itself.

IV. Outline of organisation and methods in the dissertation

A. Organisation of the dissertation

The dissertation comprises four parts. The first of these is concerned with situating current South African transcultural psychiatry⁵. This is undertaken by means of an overview of the local literature over the past fifteen years, a discussion of issues involved in studying and theorising about the relationship between apartheid and mental health, and a consideration of the question of cultural relativism as realised in South African psychiatry.

In Parts 2 and 3 I present and discuss findings from empirical research conducted in units of a psychiatry department attached to a major liberal English-medium South African university. The position of psychiatry in such a setting (as opposed, say, to an Afrikaans-medium university hospital) is particularly interesting for social analysis. The department, as will be seen, clearly enforces segregation of patients by race and a range of attendant racist practices but has an explicit non-racial ideology. One of the questions to be considered is that of how clinicians working in this context participate in reproducing a system with which they are, on the surface at least, in disagreement. Two major paths to this participation are through social practices in the system under study and through clinicians' perceptions of their own position in hierarchies of professional power.

Part 2, then, explores aspects of psychiatric ward rounds at two key sites in the system under study. The first of these is the psychiatric casualty emergency unit, which for most patients, regardless of race, represents the point of entry into the psychiatric hospital realm. The second site at which ward rounds are studied is that of the section of the large psychiatric institution in the hospital system under study which caters chiefly for Black⁶ psychotic patients.

Chapter 1: Preface

The third part of the dissertation discusses interviews I conducted with psychiatric registrars working in the hospital system. Each registrar participated in a loosely structured interview dealing with a number of areas pertinent to questions of race and culture in South Africa. In the context of a second interview I elicited registrars' responses to standard questions dealing with vignettes constructed to tap assumptions, opinions, and stereotypes about patients from different racial backgrounds.

The material gleaned for Parts 2 and 3 of the dissertation in particular suggests ways in which it may be helpful to conceptualise the relationship between professional psychiatric culture and its construction and maintenance of patient identities, and particularly those of black patients. In Part 4 - the brief concluding section of the dissertation - I argue that without examining this relationship it is not possible for a transcultural psychiatry to do anything other than reify culture and, paradoxically, produce an image of patients which is fundamentally decontextualised. I argue further that analysis of the type presented in this dissertation is important for planning towards the development of psychiatric care in a post-apartheid South Africa.

B. A note on theory and methods

Because of the scope of the dissertation, the nature of material collected, and the variety of methods used, I have decided against following the convention of presenting in the standard order of theory - methodology - results - discussion. Theoretical and methodological issues are instead discussed at various points throughout the work, with discussion frequently accompanying results. I have decided to present in this way not solely because it should make for more easily digestible material. The entire dissertation is informed by an alternative to the empiricist notion that theory, method, results and discussion are conceptually separable. There is no sense in which data can exist apart from the way that it has been collected or in which discussion and interpretation of data can take

place without the simultaneous operation of assumptions and theory, explicit or implicit (Gergen, 1982; Harré & Secord, 1972).

This observation, though now by no means original in hermeneutically-oriented social science, is especially crucial for the current study. One of my central theses is that for South African psychiatry to succeed in responding appropriately to the issue of cultural diversity, it is necessary for the fabric of South African psychiatry - the questions it asks, the silences it preserves, the talk it encourages and elicits - to be 'unpacked' (cf Young, 1987, 1988). In the same way, I must allow, and indeed attempt to engage in a similar unpacking of my own work. The methods I use are neither neutral nor ahistorical. The conclusions I draw come not from the data but from the way that I have permitted the data to speak to me. Theory and method, then, are everywhere.

From a technical point of view, most of what I present is rather simple. Statistics are used minimally. I have no objection to the use of complicated designs and statistics, but am also aware of the pressures on researchers to produce technically intricate work for the sake of demonstrating ability in abstruse areas. I do not believe that the topic at hand would be well served by flight into unnecessary technicist manipulations. This dissertation, essentially, is a narrative, with all the social, moral and political consequences and underpinnings that the telling of stories or of tales implies (Clifford & Marcus, 1986; Malcolm, 1989). It is for the reader to decide whether the story is well told.

Notes to Chapter 1

1. I confine myself here to debates concerning broad differences between the texts and the camps they can be seen to represent. It should be noted that debates of a rather different order followed the publication of the first edition of Littlewood and Lipsedge's text, but these are not germane to the current argument (Littlewood & Lipsedge, 1989).
2. The terms 'relativism' and 'universalism' will be discussed at more length in Chapter 4. The changes made (and those not made) to Leff's book in its second edition are interesting and worthy of careful attention. This is, however, beyond the scope of the present argument, which is concerned with providing a broad outline of the international context for South African transcultural psychiatry.
3. For a recent excellent overview of the key features of the 'old transcultural psychiatry' and developments in the 'new cross-cultural psychiatry' see Littlewood (in press).
4. It is interesting in this regard to note that Leff (1981, 1988) begins his book by means of what he terms a 'parable' (p. 3) in which he draws an analogy between psychiatrists in different countries and butterfly collectors. Butterfly collectors striving to obtain a standard language for their taxonomies are not, presumably, called to engage in questions about the social construction of butterfly collecting itself. In this respect they are similar to 'old transcultural psychiatry' practitioners, who give scant attention to problematising their methods as social and cultural products.
5. There are many terms for the field of 'transcultural psychiatry' (Littlewood, 1985; Littlewood, in press). These include 'cross-cultural psychiatry', 'cultural psychiatry', and the more explicitly value-laden 'antiracist psychiatry' (Littlewood & Lipsedge, 1989). I use the term 'transcultural psychiatry' here because it tends to be associated with a long tradition of thinking in the field and is often used in South Africa. I do not, by using the term, intend to refer only to work identified by Kleinman (1977) as belonging to the universalist tradition of what he terms 'old transcultural psychiatry'. At this stage of the dissertation I use quotation marks to offset terms such as 'community', 'tribe', and so on. The reasons for my doing this will become clear in Part 1 and especially in Chapter 4.
6. In Chapter 2 I explain the convention I use for designation of 'racial' categories.

PART 1

**SITUATING SOUTH AFRICAN
TRANSCULTURAL PSYCHIATRY**

Chapter	Title	Page
2	An overview of recent South African transcultural psychiatric literature	12
3	Apartheid and mental health	56
4	The question of relativism in South African psychiatry	80

Chapter 2

An overview of recent South African transcultural psychiatric literature

Table of contents

I.	Introduction	13
A.	Theoretical background	13
B.	Terms and scope	15
II.	Mental health, psychopathology, and healing	16
A.	Contexts for interpreting mental health and illness	16
1.	Personality, world-view and attitudes	17
2.	The social context	22
3.	Psychological theories	24
B.	Indigenous illnesses	26
C.	Indigenous healing	29
1.	Approaches to understanding and evaluation of indigenous healing	31
2.	Problems integrating indigenous healing and biomedicine	34
III.	Cross-cultural issues in mental health practice	35
A.	Diagnosis and epidemiology	35
B.	Cross-cultural aspects of psychotherapy and counselling	41
IV.	Cross-cultural studies on anxiety and stress	45
A.	Issues in the theory and methodology of cross-cultural stress research	45
B.	Stress, alcoholism and psychosomatic disorder	48
1.	Alcoholism	48
2.	Hypertension	49
3.	Duodenal ulceration and gastrointestinal problems	50
4.	Coronary heart disease	51

V. Concluding comments	52
Notes	54

Chapter 2

An overview of recent South African transcultural psychiatric literature

I. Introduction

A. Theoretical background

This chapter begins the body of the dissertation proper, and introduces Part 1. The three chapters in Part 1 are designed to situate current South African transcultural psychiatry in three overlapping contexts: those of the recent literature in the field (the current chapter), the interface between apartheid and mental health (Chapter 3), and the operation of cultural relativism in South African transcultural psychiatry (Chapter 4). In the current chapter I focus primarily on the literature available; in the two that follow I attempt to relate literature and debates to the concerns and practices of the clinician. To argue that the local literature on transcultural psychiatry forms a context for understanding local practice is not to assert that this literature reflects the views of or is even familiar to every local clinician. I am suggesting instead that the writings of the transcultural psychiatry field in South Africa can be viewed as explicating core concerns and ideals in the area. The actual relationship between this literature and the individual clinician will differ greatly from clinician to clinician and context to context.

The overview which appears in this chapter serves two central functions. Firstly, it provides a context of writing against which the empirical data of Parts 2 and 3 were collected. Local South African terms (such as those for what have been described as local culture-bound syndromes) will be introduced and discussed here, as will the parameters of debates concerning issues of culture in South African psychiatry. The second and more important function of this review however is to treat the material reviewed not simply as a source of facts or background information but as data. By this I mean that in the review that follows

I attempt to draw out key themes which demonstrate the construction of culture, and, more particularly, 'Black culture' in South African writings which have a bearing on psychiatry. At many points, therefore, I am concerned more with method and theoretical assumptions than with 'results'.

This is not a review which sees as its purpose the laying out of the already existing 'facts' in an area as a basis for the addition of more such 'facts' to an accumulated store of knowledge. Throughout the dissertation I align myself with an alternative view - one which asserts that realities in science and other disciplines are constructed according to assumptive contexts, and that knowledge in any given area is not necessarily cumulative. This is a view which appears in various forms in the philosophy of science (e.g. Kuhn, 1970), in psychology (e.g. Kelly, 1955), in medical anthropology (e.g. Good & Good, 1981), and in the study of psychiatry itself (e.g. Kleinman, 1988a).

One important implication of such an approach for the study of psychiatry in particular is that any text discussing the madness of other people is at the same time defining and revealing its own assumptions. Defining the madness of others is at the same time defining the boundaries of one's own sanity (cf Littlewood & Lipsedge, 1986). This theme will be dealt with more fully in Chapter 3, which considers the issue of relativism in South African psychiatry. The theme recurs in various forms in the discussion of empirical data later in the dissertation.

The fact that I do not regard this literature review as being primarily concerned with the presentation of facts does not imply that I have licence to make what I will of the South African transcultural psychiatry literature. By attempting as comprehensive as possible a coverage of the writings on South African transcultural psychiatry over the past 15 years, I hope to be in a position to argue for the existence of trends and tendencies in the literature by referring at almost every point to a number of texts. It is possible to speak of trends only in the context of a knowledge of the parameters of a field as a whole.

My decision to opt for breadth of coverage has two important costs. The first of these is that for reasons of space the attention generally given to any particular text is very brief and necessarily superficial - though not, I hope, inaccurate. The second problem is that comprehensiveness of cover has required the restriction of the time period for material reviewed. This is an undeniable drawback particularly in a work concerned with the social construction of knowledge - construction which occurs in an historical context (Gergen & Gergen, 1984; Louw, 1986). To avoid an entirely ahistorical approach I do at times discuss key¹ material published before 1975, and relate current views to historical developments inside and outside South Africa. As I hope this dissertation will contribute to showing, however, a history of South African transcultural psychiatry is an important project which needs to be undertaken².

B. Terms and scope

South Africa is a country with a highly heterogeneous population and a country in which differences between 'racial' ('ethnic', 'cultural') groups are written into the law. According to the Population Registration Act of 1950, amended at various times, every South African belongs to one of a series of mutually exclusive groups: Black, coloured, Indian and white³. South Africa is also a polylingual society, and native speakers of Black languages (such as Zulu and Xhosa - both of which form part of the Nguni language group - Pedi, Tswana, North and South Sotho among others) are by law divided into ethnic subgroups along language lines. On the whole, South African transcultural psychiatry tends to accept the idea that cultural differences exist, but the use of legally defined categories as a basis for explanation of culturally determined differences is controversial (Boonzaier & Sharp, 1988; Bourne, 1989; Sharp, 1980; West & Boonzaier, 1989).

The rubric transcultural psychiatry is used in this review broadly to include any material which seeks to relate manifestations of distress and healing to social factors particular to

various groups in South Africa, or to the sociopolitical system which affects and defines them all. Some of the material to be reviewed, therefore, will not be transcultural in a narrow sense, and some of the authors discussed do not use the term for their work⁴. I shall not consider to any degree differences within legally designated cultural groups, and within the white group in particular. This does not imply that these groups are homogeneous, or even that differences within groups are necessarily smaller or less important than those between them. The lack of emphasis on potential differences within legally defined groups simply reflects the paucity of work on such issues.

The review falls into three broad sections. The first examines issues in the understanding of indigenous modes of expression of distress and healing. The second section considers transcultural factors in the development and delivery of Western mental health care and deals specifically with the areas of diagnosis, epidemiology and psychotherapy. Key factors in the understanding and application of transcultural aspects of stress are dealt with in the third section.

II. Mental health, psychopathology, and healing

A. Contexts for interpreting mental health and illness

Three broad and overlapping approaches have been used in South African research to create a context in which to understand manifestations of distress and healing. The first approach uses as an explanatory device the concept of inherent features characteristic of the psychological structures of group members. Proponents of this approach would argue to differing degrees that there is a specific personality, world view, and set of attitudes to mental illness in each South African group. The second approach (which to some extent can be seen to have provided a basis for the first) attempts to locate illness and healing approaches within a broader social context. Finally, there are those authors who have used psychological theories as a framework for understanding the phenomena they observe. Each of these three approaches will be reviewed in turn.

1. Personality, world-view and attitudes

The concept of the 'African personality' has a long history (De Ridder, 1961; Erasmus, 1975; Wober, 1975), and some current work in the rest of Africa relies implicitly on such a construct (Odejide, 1989). The basic qualities of 'natural' communication and integration with emotional life are commonly thought to characterize the African personality. Blacks are said to be closer to nature than whites (Cheetham & Griffiths, 1982a, 1982b), and it is often argued that Westernization has affected the basic African personality (Minnaar, 1976) in a harmful, if not directly pathogenic manner (Henning, 1982).

The methodological problems in studying the 'African personality' are enormous (Ben-Arie, 1977). In addition, though the concept has been used in a laudatory way by authors who have connections to negritude philosophy and Black consciousness (Manganyi, 1973), the idea of a distinct, 'natural' African personality has been shown by some to be potentially discriminatory. It is seen as either simplistic and needlessly essentialist (Couve, 1984) or potentially a vehicle for arguing that the intellectual or scientific realm is not the true province of the Black (Houtondji, 1983; Wober, 1975, p. 167). This criticism is particularly apposite when the 'African personality' is seen as a barrier in the path of the Black person's adjustment to the (white dominated) workplace (Bakkes, 1985) or to the process of learning. Combining both reification (Taussig, 1980) and reproduction of the myth that the realm of the intellect is that of the white person, Carstens (1985) argues that culture is a possible obstacle in the way of learning ('moontlike leerbelemmerende faktor', Carstens, 1985, p. 15) in the case of Blacks. Carstens writes:

The Western world in which the contemporary Black person operates emphasises the individual, technology, science, a monetary economy and the social philosophy of a competitive society in which time is extremely important....

In contrast with this the Black man to a large extent experiences a static pattern of life. Values and norms are related primarily to the clan and the extended family, and instruction is directed solely towards group solidarity and sanctioned behaviour patterns.

It is thus understandable that the modern Black man is 'trapped' as a result of his traditional roots and as a result seldom displays the courage and initiative to explore the world freely and to risk entering terrains beyond the sphere of those familiar to him⁵.

The astonishing and inexorable 'logic' of this quotation links together many images. Blacks are seen as different in personality from whites; 'the Black intellect' is viewed as inadequate; Blacks are portrayed as inherently uninterested in any intellectual activity; and are said to be lacking in the personality characteristics ('courage' and 'initiative') to explore the world. The racist potential in the 'African personality' concept is clear.

Various South African authors have attacked the concept of the 'African personality' as it is used in applied fields of study such as transcultural psychiatry (Hayes and Nzimande, 1984; Nzimande, 1984; Swartz, 1985b; Swartz & Foster, 1984), but it continues to be used. An interesting feature of this hypothesized personality is that even if it has apparently disappeared in a Westernized Black, it is argued that it can reappear at times of stress (Cheetham and Griffiths, 1980).

Objections to the 'African personality' concept, or 'pagan soul' as it has been described by one author (Laubscher, 1937, 1975) are directed not only to the content of the concept, but also to the structure of the argument employed by its proponents. Those using the 'African personality' concept often explicitly or implicitly use a series of polarities such as natural/unnatural, rational/irrational and inherent/acquired or imposed, which provide mutually exclusive headings under which behaviour can be categorized (Bakkes, 1985; Booyens, 1986; Carstens, 1985; De Villiers, 1985; Makwe, 1985; Mfusi, 1984; Setiloane, 1987; Shuda & Matthews, 1988; Sokhela, 1984; Wajsman, 1986). Milazi (1986) seems to accept the validity of categories but argues as well for careful examination of the socioeconomic context. Proponents of the decontextualised categorical approach (e.g. Cheetham & Griffiths, 1980; Edwards et al, 1983a) often quote Hammond-Tooke's (1975) paper on 'African world-view and its relevance for psychiatry' in support of their approach. Hammond-Tooke does in fact argue for a distinction between an African or 'pre-scientific'

world-view and a scientific one. He maintains that the question of WHY rather than HOW misfortunes occur is central to the African world-view and indicates that sorcery or the relationship with ancestral shades are held responsible for upsets in the usual order of things. Hammond-Tooke's paper of 1975 is a very condensed distillation of a more comprehensive work (Hammond-Tooke, 1981) and though the earlier work does refer to complexities of theory it presents its material forcefully and at times categorically. It is probably for this reason that the paper has been integrated into psychiatric thought but has also laid open the way for a reified and, paradoxically, decontextualized interpretation of the 'African world view'. Hammond-Tooke's (1989) recent volume on African medicine is likely to be used in a similar manner (Schoeman, 1989).

Black health and illness concepts have attracted considerable research. Cheetham and Cheetham (1976, p. 39) argue that amongst rural Xhosa people 'abstract concepts are limited and ego defence mechanisms include projection, displacement and rationalization but cognitive disturbances are not regarded as important'. Quite clearly, the problems associated with the 'African personality' concept manifest themselves in this type of approach which argues essentially that the realm of the intellect is somehow not available or important. Similarly, a *South African Medical Journal* editorial in 1979 implies that Blacks are at a lower stage of evolutionary progression from belief in witchcraft to belief in science than are whites (cf Swartz, 1985b).

Jansen (1983), Daneel et al (1984), and Uys (1986) argue for the necessity of differing modes of service based on differing views of illness in patients. Daneel et al conclude from their survey of 30 Black households in Bloemfontein that the respondents have a 'holistic health concept' (p. 34) and that 'medical information services and Christianity have altered their concept of physical illnesses, but psychiatric illnesses are still explained in traditional terms' (p. 34). Edwards et al (1983b) came to similar conclusions in a study of Zulus in Zululand. Most respondents had 'modern medically oriented reactions' as opposed to 'traditional/cultural reactions' to medical illness, whereas most respondents subscribed to

'traditional African supernatural theories' of mental illness alone or in combination with 'bio-psycho-socio-cultural psychiatric theories'. An interesting feature of the findings was that trends away from traditional theories were observed when comparing Black university students to urban Blacks, but these trends did not hold up upon further specific questioning about ancestors or sorcery as possible causes of illness. Furthermore, in a study of theories of illness in psychiatric patients, Edwards et al (1983c) found a significant association between psychiatric diagnosis and the particular theory of illness used by the patient. For example, psychotics were more likely to view their illness as having been 'sent' through sorcery, than were others.

These findings suggest

1. that it may be possible to hold a range of potentially conflicting attitudes to illness simultaneously, and
2. that there may be an interaction between the nature of a misfortune and the explanation given to it.

These observations call into question the notion of a linear movement away from the 'traditional' towards the 'modern'. Findings such as those of Daneel et al and Edwards et al, furthermore, beg the question of the extent to which *non-Black* South Africans use traditional explanations for psychiatric illness, and the role of 'unscientific' explanations of these groups. This issue has not been addressed comprehensively. It is interesting, however, that a strongly-worded call for a return to traditionalism has come from a South African Muslim medical practitioner. Karim (1986) argues for an 'Islamisation of psychology', and his call must be interpreted in the light of current developments in the politics of modern Islam, and the role of the emotions in these developments (cf Good & Good, 1988). By analogy, the use of 'traditional African' concepts of health and illness may fulfil an important function within liberation or Black consciousness ideology (cf Manganyi,

1973), and may not be a sign of 'evolutionary immaturity' at all, but rather part of a national pride strategy. There is a striking lack of attention to this potential explanation for use of 'traditional theories of illness' in some cases.

The question of how communities actually manage the mentally ill (i.e. how attitudes translate into practice) is dealt with by many of the above authors. In addition, Msengi and Daynes (1981) found that relatives primarily and then neighbours tend to manage the illness of Black patients in the Transkei. Watts (1980) found that Black and Indian householders in the Durban area made extensive use of Western medicine but he felt that use of traditional healers in both groups may be underreported. As part of a larger study, De Beer (1980) reports that roughly one sixth of the 1516 Black males surveyed in three South African provinces admitted to having consulted what he terms 'witch doctors' in the past year and about 60% of these visits were for the treatment of a disease.

There are few South African surveys of attitudes towards the mentally ill. The extended family is however commonly mentioned as helpful in management of the disabled. This family acceptance may arise from economic necessity rather than from a positive attitude to the mentally ill (Elk et al, 1983)⁶. It also appears that there may be an association between social class and the acceptance of the mentally ill (Van der Burgh, 1983a).

2. The social context

The question of context is of necessity addressed in anthropological or ethnographic work. Berglund (1976) includes discussion of mental health in a broad study of Zulu thought patterns and symbolism and thereby avoids the problem of deciding what falls within the province of the medical or mental health field. Ngubane's (1975, 1976, 1977, 1981) influential studies on health and disease amongst the Zulu attempt to place the understanding of disease within an ecological context. She raises the issue of the distinction between natural causes of illness, illness related to sorcery and that related to the ancestors. Her detailed ethnography covering many areas serves as a foil for the tendency in South African transcultural psychiatry to focus rather strongly on the mysterious and exotic.

Using material from a study on the Tswana to illustrate her argument, Comaroff (1981) raises questions about the wisdom of viewing medical anthropology as a discipline separate from the rest of social anthropology. She attempts firstly to reintegrate medical anthropological findings within the context of global sociocultural systems and also to provide a way of understanding illness and healing as it changes through history. Her approach is thus in marked contradistinction to those who postulate the existence of an inherent and unchanging 'African personality'. In a later work, Comaroff (1985) uses material which could according to some definitions be termed 'medical' to explore structures of resistance in South Africa. Healing rituals, Comaroff argues, fulfil an important social and political function far beyond their use in the alleviation and patterning of individual distress. From a similar but less intricate theoretical perspective to Comaroff's early work, Mills (1983, 1985, 1987) attempts to recontextualize *intwaso* amongst Xhosa-speakers into everyday social and health practice. *Intwaso*, which is referred to as *thwasa* by all other authors, is the possession state through the experience of which a Xhosa diviner (*igqira*) is 'called' by the ancestors and begins training in her or his profession. Details of the process will be discussed later, but what is of interest here is the way in which Mills (1983, p. 29) attacks the formulations of other authors. Regardless of

whether she is entirely fair in her arguments, through her criticism Mills lays bare some of the parameters of the contextualization issue. She attacks Schweitzer (1977) for looking at *intwaso* simply as a category of illness (cf Fisher, 1986), Laubscher (1937, 1975) and Kruger (1974) for equating it to schizophrenia, and O'Connell (1982) and Soul (1975) for considering *intwaso* in isolation, and without regard for how it may fit into a pattern of a) a range of other illnesses and b) family and social structure. Mills's concern, then, is to view the apparently exotic as simply one phenomenon among many, and to explain it within a broad context. O'Connell's (1980, 1982) work provides the context of sex-role relationships as affected by the migrant labour system for the understanding of *thwasa*. Spirit possession among Xesibe women, O'Connell argues, can be related to the position of women whose husbands leave them in search of work in the cities (cf. Murray, 1981). Hammond-Tooke (1975) also refers to sex roles as important in the understanding of Black diviners, but Ngubane (1977) warns that an attempt to interpret an elaborate healing system in terms of the oppression of women runs the risk of being crude and of ignoring a range of other issues.

O'Connell's work raises the question of change as an explanatory concept in contextualizing mental illness. As was shown earlier, the concept of Westernization is one that is often used in South African studies; modernization and urbanization are other commonly used equivalents. Holdstock and Franks (n.d.) suggest that equating urbanization to decreasing belief in indigenous healers and witchcraft is not necessarily correct, though Soul (1975) provides some evidence to suggest that attitudes do differ between rural and urban Blacks. Makwe (1985), on the other hand, sees social class as more important. Soul (1975) argues further that 'culture' and 'technology' are related to mental illness but does not provide evidence in support of this. Le Roux (1978, 1979) feels that change is likely to have pathogenic effects on Blacks, and Holdstock (1981a, 1981b) feels that African holism may give meaning to emotional life and needs to be preserved. It is noteworthy however that most authors (with some exceptions, such as Comaroff, 1981) view history as something that happens to essentially passive people rather than as a

dialectical process in which people are actively engaged. It may be that this view of the passivity of 'Westernizing' Blacks is related in part to a perception of their relatively powerless role in apartheid society.

3. Psychological theories

Various psychological theories have been used to understand similarities and differences between groups. Schweitzer (1977, 1980a, 1980b, 1983, 1985) has used phenomenological psychology to attempt to understand what he terms the 'cosmology' of Nguni people. He consistently criticizes other authors for imposing inappropriate Western grids in their analyses of African experience, and attempts instead to reflect the 'lived experience' of Nguni people. Though there are problems with the claim that a phenomenological approach provides direct untrammelled access to the experience of those being observed, Schweitzer's work has been well received (Dubreuil, 1982).

By contrast, Bührmann (1978, 1980, 1981, 1983a, 1983b, 1984a, 1984b) and Bührmann and Gqomfa (1981, 1982a, 1982b) use Jungian concepts to explain Xhosa healing rituals. For example, they relate the *inthlombe* healing ritual to the Jungian concept of the Mandala, and the *thwasa* 'illness' by which healers (*igqira*) are called to their profession (i.e. a socially sanctioned form of spirit possession) is considered to be a step in the process of individuation. Bührmann also makes use of the Jungian thesis that unconsciousness is developmentally prior to consciousness to argue that the Xhosa people she studies live closer to their unconscious, instinctual natures than do Westerners. In effect, then, she is arguing that Blacks are less alienated from their true natures than are rationally oriented whites. This view, of course, recalls the 'African personality' approach dealt with earlier⁷. Bührmann's contribution to South African transcultural psychiatry has been highly influential (see e.g. Gillis, 1985; Oberholzer, 1985; Schoeman, 1985). The more specifically Jungian aspects of her work have recently been taken up in an edited volume on South Africa (Saayman, in press). An interesting feature of this work is that many of the

contributions concern themselves not only with the production of images of Black South Africans but with the production of a concept of 'Africa' itself. Africa is seen as primal, instinctual, irrational, and maternal, and is discussed in terms very similar to the 'African personality'. Psychoanalytic influence on the field has been slight, with the work of Lee (1969) being the last major contribution in that tradition. Littlewood and Lipsedge (1989) discuss Laubscher's (1937) use of psychoanalytic concepts, amongst others, in the production of an essentially racist text.

Cheetham and Rzadkowolski (1980) explicitly reject psychodynamic theory as useful in providing a context for the study of mental illness in different South African groups on the grounds that it focusses on the intrapsychic at the expense of the group. This criticism seems not to take account of the extent to which psychodynamic theory is in fact concerned with the social. In particular it does not give credit to recent attempts to link psychodynamic theory to other structuralist endeavours in areas such as anthropology, semiotics and Marxism. Cheetham and Rzadkowolski suggest, on the other hand, that general systems theory with its emphasis on the study of dynamic wholes provides a framework within which researchers can study a range of interacting systems in a potentially non-reductive way.

Further uses of theory will be discussed where relevant in the following sections. However, it is true to say that the overriding context in which distress and healing are understood in South Africa lies neither in psychological nor social theory. Instead, emphasis tends to lie on the postulated existence of an African personality, world-view or inherent cultural essence.

B. Indigenous illnesses

This review will not list all the 'culture-bound conditions' that have been identified by various authors in South Africa. Such a list would be excessively long and diverse (see e.g. Edwards et al, 1982; Le Roux, 1973; Schweitzer, 1977; Wessels, 1984). More fundamentally, however, the issue of defining a 'culture-bound syndrome' is controversial and complex (Littlewood & Lipsedge, 1986; Lock, 1987; Prince, 1985; Prince & Tchenguiz, 1987; Simons & Hughes, 1985; Swartz, 1985a). The procedure for the construction of a taxonomy of culture-specific phenomena suggests that these exist as empirical entities and are constellated according to the same, supposedly culture-free, principles as those thought to operate in British or United States psychiatry.

The study of culture-bound phenomena will be treated here as a study of methodology and epistemology rather than of taxonomy. An attempt will be made to explore the extent to which authors have considered the social function of these phenomena (cf Lee, 1981).

In discussing models of illness causation amongst Zulus, Ngubane (1977) notes the distinction between *umkhuhlane* and *ukufa kwabantu*. The *umkhuhlane* category consists of illness that 'just happens' (p. 24) such as smallpox or influenza. Medicines to cure *umkhuhlane*, according to Ngubane, are regarded as potent in themselves and are not ritualized. The illnesses are seen as universal and treatable biomedically. Ritualized healing and indigenous approaches, then, are more generally used to deal with *ukufa kwabantu* (diseases of the African people) which often cut across lines of particular African language groups (such as Zulu, Pedi, Shona or Tsonga) but are specifically African (Ngubane, 1977, p. 25). It is with this second category, then, that psychiatrists are commonly concerned. If reified into a hard and fast empirical categorization instead of taken simply as an epistemological device, however, the distinction made between 'African' and 'non-African' illness, so prevalent in the literature (e.g. Cheetham & Cheetham, 1976; Edwards et al, 1983b; Le Roux, 1973; Wessels, 1984), can disallow certain types of analysis.

For example, Mills (1983, 1985) indicates that an illness such as tuberculosis can be seen in purely biomedical terms in some contexts and as having 'African' elements in others.

Ngubane (1977) points out that concepts of ecology are central in any Zulu idea of health, and explanations for ill-health may lie in interpretations of environmental imbalance. Indigenous illness and misfortune may result from sorcery (*ubuthakathi*) of various types which may involve the employment of familiars or the insertion of noxious substances in the environment. By contrast, misfortunes or illness related to the ancestors generally arise when a person (or member of his or her family) has acted in some way to disturb social order - and hence, a balance of a certain kind. The possibility of pollution also implies an imbalance in the permeability of boundaries.

Spirit possession is the area in which psychiatry has traditionally been interested. Ngubane (1977) distinguishes between i) traditional spirit possession of a Zulu diviner (*isangoma*) (this corresponds to *thwasa* mentioned earlier in connection with Mills's work on the Xhosa), which is 'good and desired' (1977, p. 147); ii) *indiki* possession which seems to have emerged at the beginning of the twentieth century and according to Ngubane is closely related to 'African industrial development' (1977, p. 142); and iii) *ufufunyane*⁸, an even more recent possession state (starting roughly in the 1920s). *Indiki* is a deceased male spirit which enters the chest and manifests in a deep voice and a foreign language. Treatment is undertaken by an *isangoma* who has herself been afflicted by *indiki*. *Indiki* possession may lead to membership in a spirit cult and the sufferer herself may become a diviner able to treat *indiki*. This good outcome is not inevitable, however, and there is always the potential danger of *indiki* placing alien spirits in the environment. Thus *indiki* is not a purely desirable possession state. *Ufufunyana* on the other hand is described by Ngubane (1977, p. 147) as 'thoroughly bad'.

The question of what constitutes 'good' or 'bad' possession is closely related to whether behaviour of a certain type constitutes 'mental illness' or is 'culturally acceptable'. Even

when it is accepted that a person is 'mentally ill', there is often a question of differentiating between psychotic and hysterical phenomena. This question is certainly not confined to South Africa (Swartz et al, 1985) but has attracted much local attention. Thus, Van der Hoofdt and Erasmus (1976) raise the question of whether *malopo* which they describe both as a way in which Pedi people explain illness, and as a form of spirit possession, in fact constitutes a psychiatric syndrome. They conclude that the nature of the relationship between *malopo* and psychiatric illness can best be studied by participant observation methods and knowledge of ethnology and comparative religion. Bührmann (1982) argues that a distinction needs to be made between *thwasa*, which is the result of a positive 'calling' from the ancestors, and bewitchment, which she sees as being related to a negative relationship with the ancestors. Bührmann's formulation is that bewitchment, which can be associated with mental illness, is the product of a negative attitude to unconscious material whereas *thwasa* involves the acceptance of such material. This analysis, then, considers possession in its various forms to be the product of a single psychological structure, and is obviously different from those which employ historical considerations. Schweitzer (1977, p. 144) feels that a crucial factor in the assessment of what he terms 'categories of experience' amongst Xhosa people lies in an understanding of a dynamic relationship between the ancestors or shades, witchcraft, which is manifested by familiars, and sorcery conducted by enemies.

Mills's (1983) findings offer a contrast to those of Schweitzer, in that to her the boundaries of categories are much more fluid, with the possibility that different types of illness may merge into one another. It may be that Schweitzer and Mills obtained different results because Schweitzer was working in a rural area in the Eastern Cape and Mills in Guguletu, Cape Town. However, it is equally feasible that their findings may be attributed to different theoretical and methodological orientations, as indicated earlier. Through her fieldwork in rural Lesotho, Heap (1985) demonstrates that it is neither necessary nor desirable to assume that people have a rigid natural/supernatural distinction between different illnesses.

Differing approaches to the understanding of 'Black illnesses' can be seen further in a comparison between the interpretations of *amafufunyane* made by Edwards (1983a) and Weiss (1984). Edwards relates *amafufunyane* to spirit possession reported in the New Testament and sees the condition as an adaptive means of coping with social stress. Weiss (1984), by contrast, implies that *amafufunyane* may be seen both as a method of *dealing* with social imbalances, as Edwards suggests, and also as *contributing* to social upheaval. In fact, it can be seen as interfering with changes in patterns of health care beliefs. The social function of the condition, then, may be understood to be operating at several levels, ranging from simple individual 'stress release' to an exacerbation of stress levels in an entire community, which may affect that community's use of healing. Regardless of which interpretation of *amafufunyane* is correct (and it is quite possible that different interpretations pertain for different levels), the issue of illness as a means of coping is more complex than would first appear. To speak about South African 'culture-bound syndromes' as though these are uncomplicated, reified psychiatric entities is to close off discussion about their social construction and function.

C. Indigenous healing

In this section I shall review approaches to the understanding of local healing methods, including those undertaken under the auspices of the African independent churches. As in the previous section, I shall devote most of my attention to issues raised in the literature, rather than to the development of lists of types of healers and healing. Lamla's (1976) study of *amagqira* (Xhosa diviners) in the Transkei, for example, provides such a list in one rural area and Farrand (1980) provides similar information for Johannesburg; in this section I have tried in the main to discuss principles common to all. It should be noted that dualism of the type mentioned earlier in connection with the 'African personality' affects this area as well. In his recent chapter on psychopathology in 'traditional Black South Africans'⁹, Schoeman (1989) reasserts the image of linear movement from the 'traditional'

to the 'modern' Black, and the concluding sentence of the chapter is particularly interesting:

..In general it is accepted that sicknesses sent by the ancestors or the witches or caused by pollution cannot be treated within the Western system, and it is only when traditional treatments are unsuccessful that Western services are used¹⁰.

This quotation can be seen to reveal a fundamental ambivalence about 'traditional' Black world view, illnesses, and healing strategies, one which clearly plays itself out in various forms in much of the local literature. On the one hand, Schoeman asserts that Western treatments are unable to care adequately for the foreign 'Africanness' of the 'traditional Black'; on the other, when the supposedly culturally appropriate services are inadequate, then the (presumably) more potent Western system is turned to. Schoeman's interpretation of why people (and, specifically, traditional Black people, as he calls them) make use of different services is simplistic particularly in the South African context. According to Schoeman, 'the choice is usually the result of the patient's specific interpretation of his sickness'¹¹. This voluntarist interpretation makes the assumption that Black people in South Africa simply 'choose' one system over another because of their 'world-view'. It overlooks the fact that Black South Africans, and particularly rural Black people, amongst whom there are presumed to be more 'traditional Blacks', are grossly underserved in terms of medical and psychiatric services relative to whites and simply do not have a range of appropriate 'Western' services from which to choose. It is impossible to say that people are making free choices when the alternatives are not equally available and accessible¹².

Boonzaier (1985) has drawn attention to the inadequacies of the assumptions either that *all* Blacks consult *only* traditional healers, or even that some Blacks ('non-Westernized' or 'uneducated') consult only traditional healers, and Spiegel & Boonzaier (1988) draw attention to inadequacies in the concept 'traditional' in general as it tends to be used in South Africa. In this regard, Farrand (1984) found that Black patients use and approve of a

variety of healing systems including biomedicine, and that to divide Blacks into 'traditionals' who use traditional treatments and 'Westernised' who use Western treatments is to oversimplify. A further danger in South African practice is to assume that Blacks consulting Western doctors necessarily have 'naïve' or 'traditional' attitudes to Western medicine itself, and can automatically be satisfied for example by the administering of tablets and injections purely as placebo (Mfenyana, 1988).

1. Approaches to understanding and evaluation of indigenous healing

Ngubane (1976, 1977) provides a framework for the organization of healing amongst Zulus in the Nyunswa district. In the first place, she distinguishes between the *inyanga* ('doctor') and the *isangoma* ('diviner'). The *inyanga* (usually a man) becomes apprenticed to another *inyanga* and after a training of usually not less than a year becomes qualified to dispense special herbal medicines. An *isangoma* is usually a woman who is chosen by her ancestors and who after a period of accepted spirit possession trains to develop her clairvoyant powers, once again as an apprentice. Both the *inyanga* and the *isangoma* have knowledge of herbal medicine, which is often imbued with colour symbolism, but only the latter can divine using the ancestors. Within the *isangoma* group there is a further differentiation of practitioner types. Similar basic distinctions have been reported for other groups such as the Xhosa, and the focus of psychiatric interest is generally speaking on the diviners (e.g. Bührmann, 1980, 1983a, 1983b; see De Villiers, 1984, for a discussion of popular medicine amongst Xhosa speaking farm labourers).

In addition to the 'traditional healers' in various Black groups, there is a strong emphasis on healing in the African independent churches, which cuts across particular group lines. These churches are run by Blacks and enjoy a large following throughout the country. According to West (1975a, 1975b) who has made an extensive study of these churches, approximately 25% of the total Black population in Southern Africa are congregants. In general, the Ethiopian-type churches disapprove of belief in ancestors and cult activity whereas Zionist-type churches approve these.

The Zionist churches are related to American pentecostalism and use healing based upon the power of the Holy Spirit (West, 1975b, p. 190);. Hence it is generally within the Zionist churches that there is an integration of beliefs in the ancestors and Christianity, and healing rituals may bear similarity both to 'traditional' practices and to pentecostalism (Edwards, 1983b). A complicated theology integrating apparently disparate beliefs has developed, and the fact that qualified *izangoma* (plural of *isangoma*) may become converted to prophets for the church, demonstrates a practical integration as well.

The obvious psychiatric question to be asked in this section is that of whether the various healing approaches work. This is an issue fraught with methodological problems (Schweitzer, 1980a) and begs the question of at what level 'helpfulness' can be seen to exist. Some authors are concerned to examine the role of healing within a broad social context, seeing it as part of *social* development (e.g. Berglund, 1976; Comaroff, 1981; Ngubane, 1977). At the more essentially psychiatric end of the spectrum, helpfulness is seen largely in terms of symptom relief even if the social context is also given attention (Bührmann, 1980; Cheetham & Griffiths, 1982b; Holdstock, 1978, 1979; Psychotherapeia, 1977, 1980; Robbertze, 1978, 1980; Schoeman, 1989; Van der Hoofdt, 1979). It is noteworthy that only one of these authors suggests that indigenous healing may at times be clinically useless or worse (Robbertze, 1978); many imply or state that it may be more effective than 'Western' psychiatry. There are many clinical accounts of doctors failing to cure and then traditional healers succeeding (Keen, 1978); reports of failure on the part of healers but subsequent success of 'Western' doctors are extremely rare. Arguments strongly critical of traditional healers (Roux, 1977) are easily refuted as theoretically unsound (Dick & Murray, 1978; J. Kruger, 1978). Many authors who support traditional healing see its clinical value as intimately related to the 'holism' of the 'African world-view' mentioned earlier in this chapter; others have suggested that mental health professionals writing on the subject of indigenous healing tend at times to replace a sympathetic but critical evaluation with somewhat romantic praise of traditional approaches (Swartz, 1985; Swartz & Foster, 1984).

The question of whether indigenous healing is good or effective relative to psychiatry can be addressed indirectly by comparison of methods. Thus, Stott and Browne (1973) argue that Xhosa *amagqira* recognise clinical symptoms along the lines Western doctors do. Bührmann (1983b) argues that *amagqira* and Jungian analysts share similar training experience particularly in that both systems require the trainee to confront and attempt to integrate the unconscious. Dream analysis among *amagqira* is also seen to have similarities to analytical and other methods of dream interpretation (Bührmann & Gqomfa, 1982a; Schweitzer, 1983) and part of the interest in the use of dreams by indigenous healers can be attributed to the parallels with psychology and psychiatry (Farrand & Holdstock, 1982; Holdstock 1981b). Indigenous healing has also been seen to have parallels with Rogerian client-centred therapy (Holdstock, 1981a; Mkhwanazi, 1986), with parapsychology (Holdstock 1980; Van der Hoofdt, 1980), and with family therapy (Bührmann & Gqomfa, 1982a). The fact that so many points of similarity have been argued to exist suggests firstly that there is considerable diversity in healing procedures and secondly that the comparisons are being made at a very high level of generality. Certain features, such as the use of dreams and dance and movement (Bührmann, 1981; Edwards, 1983b; Van der Hoofdt, 1979), are fairly universally considered to typify indigenous healing methods.

A more formal comparison between practices of indigenous healers and those of clinical psychologists was undertaken in Zululand by Edwards et al (1983a)¹³. Three psychiatric outpatients were each interviewed for 45 minutes by each of 3 clinical psychologists, an *isangoma*, an *inyanga*, and a Zionist faith healer (*umthandazi*). The practitioners interviewed in any way they chose. It was found that the healer group, (the *isangoma*, *inyanga* and *umthandazi*) relied more on 'supernatural' theories of illness than did the clinical psychologists, but that overall the practitioners tended to agree on severity of disorders. Patients did not show consistent preferences for any particular type of practitioner. Unfortunately, Edwards et al (1983a) present their data so sketchily that it is

not possible to make a full assessment of methodology or to understand the full import of some of their findings, but the results are nevertheless interesting.

D. Kruger (1974, 1978), like other authors, has suggested that there are similarities between divining and psychotherapy. Addressing the quite commonly-held belief that diviners are psychiatrically disturbed as a result of the *thwasa* state, he studied diviners using the Rorschach and Thematic Apperception Test. He found them to be a 'normal (although self-restrictive) group' (D Kruger, 1978, p. 9). He also found no psychometric evidence for the argument that the *thwasa* state of being called by the ancestors is equivalent to schizophrenia.

2. Problems integrating indigenous healing and biomedicine

Along with trends elsewhere, and with WHO suggestions, there is considerable local interest in the integration of biomedicine with traditional healing. Interest in integration is not confined to psychiatry (e.g. Dick & Murray, 1978; Larsen et al 1983a, 1983b), but authors such as Allwood (1979) and Robbertze (1976, 1980) indicate a particular need for collaboration in psychiatry. A mutual referral network between Western doctors and other healers is alluded to by various authors (Lethlaka, 1978; Mokhobo, 1978; Schweitzer, 1977a; Wilson, 1980). Farrand (1984) found that a sizeable proportion of Black psychiatric patients would like to consult with both psychiatrists and indigenous healers, and Mills (1983), among many others, notes that, *de facto*, people use a range of resources in illness management.

An obvious problem with the establishment of an integrated indigenous/biomedical health system is that of who holds the ultimate power. This issue, surprisingly, is often overlooked (Daynes, 1985; Oberholzer, 1985) or at best equivocated about (Mokhuane, 1986). The question of the power dynamics of any proposed collaborative scheme with indigenous healers is of course particularly crucial in the South African context. Which type of healer

is to hold ultimate clinical responsibility? Does either system (indigenous or biomedical) have the right to veto procedures which it feels may be pathogenic? Not surprisingly, South African 'Western' practitioners tend to equivocate on the issue of whether indigenous healers are to be seen as equals (Robbertze, 1980). Other aspects of this issue will be alluded to in the discussion of apartheid and mental health in Chapter 3.

III. Cross-cultural issues in mental health practice

In South Africa, the overwhelming majority of formally qualified mental health practitioners such as psychiatrists and clinical psychologists are white. Thus, most patients utilizing formal mental health services will be treated either by whites or within a system in which whites occupy the higher echelons of authority.

Although research into indigenous healing and illness is important, Western psychiatry's main concern of course is with Western methods of diagnosing and treating mental illness. Material dealing specifically with cross-cultural diagnosis and epidemiology as well as cross-cultural psychotherapy and counselling however is relatively sparse when compared with the vast amount of work on indigenous healing discussed above. Possible reasons for this imbalance will emerge in the following two chapters; this section will review the studies available.

A. Diagnosis and epidemiology

The major impetus in this field comes from the work of Gillis and his colleagues in the MRC Clinical Psychiatry Research Unit. Established in 1980, the Unit is the only formally constituted psychiatric research centre under the auspices of the South African Medical Research Council. It is strongly influenced by British empirical psychiatry.

Gillis's early study of alcoholism and mental disorder amongst coloureds in Cape Town (Gillis et al, 1965) and follow-ups (Gillis & Stone, 1973; 1977) can be seen as forerunners to current work. These studies have influenced other researchers (for example, Soddy, 1972, who studied mental illness in the Johannesburg area) and have also set the stage for a self-critical approach to psychiatric research methodology and to cross-cultural assessment in particular. For example, in a study of mental and physical illness in 150 randomly selected elderly coloured persons in Cape Town (Ben-Arie et al, 1983, 1987; Elk & Nash, 1985; Elk, et al, 1983; Nash & Meiring, 1983), standard psychiatric instruments were used but their limitations were comprehensively discussed, particularly insofar as they may yield false diagnoses. The major instrument used was the Present State Examination (PSE) (Wing, et al, 1974), and the Clinical Psychiatry Research Unit's central statement on methodology can be found in an article discussing the use of the PSE with Xhosa-speaking patients (Gillis et al, 1982). They identify three major areas affecting the use of the PSE (or any standard 'Western' instrument) with Xhosa speakers.

- (1) Invoking the Sapir-Whorf hypothesis, they point to a number of difficulties in relation to the translation of English terms, such as depression, and to the problems of dealing with subtle phenomena such as pseudo-hallucinations in translation.
- (2) They identify factors which make assessment difficult - for example, to ask a person about weight loss assumes that a respondent who may well live in very poor and deprived circumstances has access to a weighing scale.
- (3) They argue that various interpretive factors relating to cultural beliefs may affect assessment. For example, the patient's view that an illness has been sent by an enemy does not necessarily imply paranoid thinking. The explanatory construct used by Gillis et al to account for 'cultural differences' is, essentially, that of the 'African world-view' which has been discussed above.

Gillis et al's (1982, p. 143) conclusion that 'the experiential events of psychiatric disturbance as defined by the PSE exist in the Xhosa-speaking patients and it is a valid instrument' is unfortunately not supported by any data, and seems to reflect an assumption

rather than a finding (Fabrega, 1989b; Swartz & Foster, 1984). A later article about the PSE from the same Unit (Swartz et al, 1985) devotes more critical discussion to the assumptions behind the use of an instrument which sets out almost exclusively to tap universals, to internal inconsistencies in the PSE with regard to cultural phenomena, and also to the difficulties of working through interpreters. Early results of a follow up of white, coloured and Black psychiatric patients (Elk et al, 1986; Teggin et al, 1985) unsurprisingly find the universal symptom patterns which use of an instrument such as the PSE somewhat tautologically assures (Kleinman, 1977). Nevertheless, the basic data supplied by the work of Gillis and his colleagues has been highly influential. In particular, it provides a foil for most transcultural work in this country which focusses on the exotic at the expense of the mundane. It is noteworthy, however, that the technical complexity of some aspects of psychiatric research methodology used by the Unit is in marked distinction to the inadequacy with which the issue of culture is addressed (Gillis et al, 1986a, 1986b, 1989; Gillis, Jakoet, Trollip, Sandler & Elk, 1987; Gillis, Trollip, Jakoet & Holden, 1987).

The existence, manifestations, and treatment of depression among Blacks and coloureds can be seen to be a major interest of the Unit (Ben-Arie et al, 1987; Elk et al, 1986; Gillis et al, 1982). This interest can be traced to the desire to explore the widely-held prejudice that the experience of depression is the exclusive province of white people, and the studies quoted concur that if carefully probed, symptoms of depression can be elicited. The findings of Elk et al (1986) do, however, suggest that depressive features in Black schizophrenics may not be detected by clinicians. There is considerable interest in depression amongst Blacks in various centres in South Africa at present (Freed & Bishop, 1980; Oberholzer, 1986; Raubehnheimer, 1986), a fact which is in keeping with the centrality of the question of depression in cultural psychiatry internationally (Kleinman, 1977; Kleinman & Good, 1985; Littlewood & Lipsedge, 1989).

In a practically-oriented guide to psychiatrists working with Xhosa-speakers, Bührmann (1977) prefigures much of what is discussed by Gillis et al (1982), making reference to

customs such as *hlonipa* according to which women are not allowed to use certain words such as those involving the names of male figures in her husband's family. The circumlocution which this custom requires could lead the naïve psychiatrist to the erroneous conclusion that the patient experiences language difficulties. Bührmann expresses serious reservations about the 'Western psychiatric model' and unlike Gillis et al is concerned to demonstrate its culture-boundness rather than its universality. In a study which had the potential to throw light on the area of dispute between these approaches, Wessels (1976) applied various statistical measures to determine the 'natural structure' of symptoms in 100 Black male schizophrenic patients. Unfortunately, the study does not go beyond the boundaries of the inflexible clinical instrument it employs, and experiences difficulties similar to those encountered by the International Pilot Study of Schizophrenia in this regard (WHO, 1973).

Like Bührmann (1977), Cheetham and Griffiths (1981) set out to educate their audience about factors such as *hlonipa* which may affect assessment. In an attempt to evaluate psychiatric diagnoses, they studied 77 Black and 23 Indian patients referred to a psychiatric ward in a teaching hospital in Durban. To be included in the study, patients had either to have been thought to be schizophrenic by the referral sources, or diagnosed as schizophrenic by the admitting psychiatric team, or both. The psychiatric team diagnosed on Schneiderian criteria. Roughly 60 percent of those thought to be schizophrenic by referral agents were not in fact diagnosed as such by the psychiatric team. A similar proportion of those who did receive a psychiatric diagnosis of schizophrenia had not been thought to be schizophrenic by referral sources. The finding that of the 27 patients originally referred as schizophrenic, roughly two-thirds (17) were finally diagnosed as organic psychoses is particularly worrying, but unfortunately there is little in the findings which cannot be explained either by the *general* psychiatric naïveté of referral agents (which has nothing to do with culture in the sense in which Cheetham and Griffiths use the term) or (and this is less likely) the potential inadequacies of the final diagnostic system. A follow-up study of these diagnoses is not provided.

Very little data on the comparative epidemiology of mental disorder is available in South Africa. An added difficulty is that such studies as do exist often use hospital or clinic admissions only as measures of psychiatric disorder, and focus only on one group - most often, the whites (e.g. Haldenwag, 1984; Powis, 1984; Van der Merwe & Zietsman, 1982). Other studies, such as the short report by Crane (1976) on psychiatry at a mission hospital serving Blacks, provide figures but no indication of how diagnostic decisions were made.

In a hospital archives study of 143 patients seen by a Black clinical psychologist in a psychiatric outpatients department in the Transkei, Gijana and Louw (1981) found that the commonest disorders were schizophrenia, depression, epilepsy and anxiety states, and that most patients were young adults. Once again, criteria for diagnosis are not clear, and the authors also point out that the nature of referral agents strongly affects findings. Luiz (1981) reports that of 261 Black patients seen at a psychiatric clinic in Soweto, 40% were felt to be suffering from schizophrenia, 14% were thought to be epileptic and 13% were diagnosed toxic psychosis. Modified International Classification of Diseases diagnoses were used, but the nature of the exact modifications was not stated. Using DSM II criteria, Freed and Bishop (1980) found that of 1889 Black patients seen over some years in the psychiatry department of a large general hospital in Soweto, 38% were diagnosed organic brain syndrome (notably alcohol-related), 35% were schizophrenic, and 15% were diagnosed affective disorder. Minor psychiatric disability tended not to be seen. Farrand (n.d.) found that of all the patients seen in 1982 in a psychiatric hospital catering chiefly for Black migrant workers in the Johannesburg area, almost a third were diagnosed 'toxic confusional state' and over a quarter 'conversion disorder'. Other studies have also noted the apparent high involvement of toxic substances such as cannabis in serious mental illness in South Africa (Rottanburg, 1982; Rottanburg et al, 1982; Teggin et al, 1985), though a study comparing frequency of drug use in patients and non-patients has not been conducted. The question of whether and how cannabis can induce psychosis remains controversial (Solomons & Neppe, 1989), but the diagnosis of cannabis or toxic psychosis is

clearly commonly made. Of 52 Black adolescent patients admitted to Valkenberg Hospital, Cape Town, during the first six months of 1988, almost half (25) were diagnosed 'toxic psychosis' (Schoeman et al, 1989). The authors are at pains to point out, however, that like the diagnosis 'traditional illness', and, less explicably, that of 'psychosis (major depression with psychotic features)' the label of 'toxic psychosis' refers to an 'uncertain' diagnostic category (Schoeman et al, 1989, p. 2). The issue of the diagnosis of toxic psychosis and its cultural underpinnings in the South African context will be considered more fully as part of a discussion of empirical data in Chapter 6.

Conversion disorders are also thought to be common in Black South Africans, but Edwards et al (1982) feel that many culture-bound conditions may easily be mislabelled as 'hysterical' by clinicians who do not take account of the context in which they occur. Problems in diagnosis, communication with Black patients and access that these patients have to care, furthermore, may all be related to deficiencies in care (Holden, 1987; Lamont, 1988). Some issues concerning the hysteria diagnosis will be considered in Chapter 4.

A three year community survey of chronic illness in Cape Town (Dick et al, 1978a, 1978b) revealed that mental disorders comprised 16.7%, 24.5% and 16.9% of chronic illness for Blacks, coloureds and whites respectively. This indicates that mental disorder is a major community health issue for all groups. Examination of their figures yields prevalence figures for incapacitating chronic psychosis of approximately 0.1%, 0.25% and 0.05% for Blacks, coloureds and whites respectively. These figures are explicable at least partly by differing attitudes to and facilities for hospitalisation and treatment in the different groups. For example, whites may be more likely than others to institutionalise the chronic mentally ill. The relatively high frequency of psychosis amongst coloureds bears out findings made earlier by Gillis et al (1965) about psychiatric illness in general amongst coloured people in Cape Town. Carmil (1980, p. 70) reports that the incidence ratio of contact with a psychiatric clinic in Johannesburg in whites, Indians and coloureds were 6/1000, 9/1000

and 10.5/1000 respectively. Bartocci et al (1975) found that coloured psychiatric inpatients in Cape Town had more signs of personality disorganization than did Blacks. As this study and that of Carmil both suffer from serious methodological problems, no conclusions can be drawn from them.

A number of points need to be made in the evaluation of the above findings. Criteria for deciding on psychiatric 'caseness' differ so substantially from study to study that it is not possible to talk of an overall picture. Identification of mental disorders amongst coloured and white people are easier to identify than those amongst Blacks where there are usually language differences between researchers and subjects, and hence there are more research figures for whites and coloureds. A recent study of child and adolescent referrals to psychiatric services in the Transvaal and the Cape Province, similarly, cautions the reader that even the results reported within the study itself are not comparable because of non-standard methods of assessment (Schoeman et al, 1989). The global question of whether there is 'more disorder' amongst certain South African groups than others remains open. The reason for this is suggested by Allwood's (1985) comment that adequate psychiatric assessment of Black children (and, by implication, Blacks as a whole) requires considerable effort from the psychiatric team, and may also in the short term be very time-consuming.

B. Cross-cultural aspects of psychotherapy and counselling

The dynamics of cross-cultural psychotherapy and counselling in South Africa are complicated. Not only is there the issue of communication between people with different backgrounds, but the unequal status relationship between therapist and client is drawn into sharp focus in a society which legislates about and entrenches differences. Fairly standard concepts such as 'empathy' are difficult to use unselfconsciously when one is speaking of the intimacy of therapeutic contact across an enormous structural divide.

The extent to which cross-cultural psychotherapy is undertaken in South Africa has not been recorded, but given the preponderance of white clinicians, it is likely that 'cross-cultural' clinical practice is an important feature of South African psychiatry. Recognizing the fact that the bulk of mental health care within the medical establishment does not occur in the psychiatric realm, Gillis (1975) has argued that knowledge about social and cultural factors in mental and other illnesses should be integrated into everyday communication by all South African doctors with all patients. A similar view can be seen in the undergraduate medical text on human behaviour by Nash et al (1984).

These authors do not address ideological issues directly, and other authors such as Cheetham (1975) seem to have paid little attention to such factors. A danger in this field is the tendency to reinterpret the consequences of social factors in terms of individual psychological make-up. Raath (1984) used humanistic/behavioural psychotherapy group techniques to teach Black university students interpersonal empathy, warmth, congruence and assertiveness as well as 'general Western acceptability' which was measured by the rating of performance in a role play of a job interview. Raath claims that 'psychotherapeutic intervention in the assimilation of interpersonal skills of Black university students involves a study of the transition process from an African culture to a Western culture by educated blacks' (1984, p. vii). He implies equivalences between 'psychotherapy' and 'acculturation' on the one hand, and 'psychopathology' or 'poor social skills' and a postulated 'African culture' on the other.

Lambley and Cooper (1975) argue that consideration of ideology cannot be separate from the practice of psychotherapy in South Africa. They point out that the particular individual contact between a white therapist and a Black client contains within it elements of the overall relationships between Blacks and whites in apartheid society and these elements cannot be ignored. Dawes and Davids (1983) mention the fact that even the choice of how to classify patients or clients has the potential to affect the therapeutic relationship. For example, the label 'coloured' is rejected in favour of 'black' by many South Africans

classified coloured as the term 'black' is used generically for all oppressed groups (coloured, Black and Indian). A white psychotherapist who refers to his or her patient as coloured may well be perceived at least partly correctly by the patient to be incapable of beginning to empathize with the patient's position.

Strebel (1983a, 1983b) concurs with previous authors in that she feels that past experiences of discrimination are likely to affect the therapeutic relationship. She rejects as needlessly simplistic the view that the counsellor or psychotherapist must come from the same group as the client. It is more important, she feels, for any helper to understand both the facts of discrimination and the minutiae of cross-cultural communication. Applying an essentially Marxist analysis to the question of counselling in different cultural contexts, Turton (1986a) argues that many bourgeois counsellors, regardless of race, are, as he puts it, 'culturally encapsulated' (p. 85). From a very different ideological perspective, Jansen (1982) believes that medical anthropological training and practice will help to deal with cultural issues in treatment, but she does not refer to issues of discrimination. The proceedings of a recent family therapy conference (Mason & Rubinstein, 1989) are interesting with respect to the question of the perceived importance of 'cultural' versus 'political' factors in local family therapy. Some authors take up an explicitly anti-state position (Dawes & De Villiers, 1989), and others argue that the notion of 'cultural difference' can be used as a 'tacit rationalisation for the system of separate development' (Nell & Seedat, 1989, p. 40). Others argue against what is termed political 'militancy' in family therapy (Snoyman, 1989, p. 195), and support the notion of intrinsic cultural difference between Blacks and others (Tau, 1989). Even where plural use of healing systems is recognised, the concept of the 'true nature of the Black' (or of the '[primitive] African personality') is implicit:

There is a tendency for blacks to utilise many different kinds of treatment modalities, including modern medicine. However, there has been remarkably little incorporation of these foreign ideas into their thinking about problems of living and their causes.
(Lifshitz, 1989, p. 49).

In spite of many calls for 'Western' therapy to take account of local factors (e.g. Dowdall, 1982), case reports of cross-cultural therapy are rare. Edwards, Cheetham et al (1983) discuss the use of hypno-therapy in the treatment of *umego*, which they define as a culture-bound syndrome. D. Kruger (1980) presents case material of psychotherapy between an Afrikaner male therapist and a Black female client, and raises by implication the issues of transference and countertransference in work of this kind. Levenstein's (1978, 1980, 1982) work with Balint groups for medical practitioners and students is ostensibly directed primarily at middle-class practice but shows the flexibility to examine the range of feelings white helpers may have for their Black patients. It should be noted that these feelings may range from overtly negative ones to potentially equally inappropriate over-concern and desire to repair the damage engendered by South African society. Every aspect of transference, positive or negative, may be difficult for the practitioner to deal with because of the practitioner's own emotion-laden response to the injustices of this country. For example, a white therapist may encourage an artefactually hostile transference from his/her client because of the therapist's own guilt at not having suffered as much as the client. Some of these issues will be raised again in Part 3.

Characteristics of who actually seeks psychotherapy and at what stage in the progression of symptoms have not been studied in detail in South Africa. Using the Omnibus Personality Inventory, Van Zijl (1980) studied the characteristics of 30 each Afrikaans-speaking (white), English-speaking (white) and Indian students who went for counselling at their universities. He found Afrikaners to be significantly more conservative and eager to make a good impression than the other groups, English speakers to be higher in autonomy and liberalism and also more impractical, and Indians to be more withdrawn. Non-help-seeking controls were not used, so the findings are difficult to interpret.

In a theoretical investigation into the relevance of psychotherapy for Black South Africans, Ngcobo (1981) attempts to link structural theories of madness such as that of Foucault to current psychopathology in South African Blacks. He suggests that psychotherapy is not a

cure-all for social problems, and advocates a 'combinative strategy' which takes account of political factors. More than other writers, he attempts to relate the practice of psychotherapy to the theory of ideology, and though the issues he raises are not clearly worked through, he does point the way to further work of greater theoretical sophistication.

Finally, in this section mention must be made of a study of cross-cultural divination. Holdstock and Peltzer (n.d.) arranged that undergraduate white psychology students each attend a group of *izangoma* for a divination session. The results of the study are so idiosyncratically presented that they cannot be assessed by usual means, but the study serves as a reminder that cross-cultural healing is usually considered in one direction only. Furthermore, psychotherapy is undertaken in South Africa between white patients and therapists from other groups, and the dynamics of these relationships have not been explored.

IV. Cross-cultural studies on anxiety and stress

This section deals with issues regarding the measurement and evaluation of stress in different South African groups, with some attempts to link stress to psychosomatic disorder. The first subsection, therefore, deals with methodological and theoretical issues, and the second considers some of the applied work on psychosomatic disorder and alcoholism.

A. Issues in the theory and methodology of cross-cultural stress research

As in other countries, the concepts of 'anxiety' and 'stress' have come to be commonly and often very loosely used. An empiricist approach to defining anxiety more narrowly is operationally, through the use of psychometric instruments. Psychometric work on anxiety, however, which has received considerable attention in studies on Indian South Africans (Mahabeer, 1980; Mahabeer & Bhana, 1984; Spinks, 1980, 1982, 1983) tends to be rather narrowly focussed and is of obscure psychiatric interest.

During the 1970s a series of psychometric studies were conducted on different South African groups, chiefly university students (Lambley, 1980; Lison, 1976; Van der Spuy & Shamley, 1978). Standard psychometric instruments such as the EPI and the MMPI were used, and the findings on the whole seemed to indicate no great discrepancies in anxiety levels between different groups such as whites and coloureds. Overall, however, higher anxiety levels were recorded than in studies elsewhere in the world, and Van der Spuy and Shamley have sought to explain the results by arguing that apartheid society is stressful for all its inhabitants. The authors' attempts to 'diagnose' apartheid will be dealt with in the following chapter.

A study conducted in Zimbabwe but reported in the *South African Medical Journal* (Castle et al, 1976) reported some of the difficulties involved with measuring emotional stress in Africa by means of standard scales. The authors present an argument remarkably similar to that proposed by Gillis et al (1982), and the paper has been seen as relevant to South African work (Walker, 1976a, 1976b). A more specific approach to the assessment of stress was undertaken by Swartz et al (1983). These authors interviewed 150 Black residents of Cape Town to assess the prevalence and perceived impact of life events experienced over a six month period. The list that emerged was similar to those that have been published elsewhere, but it appears that events related to police contact and the effects of poverty, among others, had a more than expected prominence in respondents' lives. The authors themselves question the interpretive value of the exercise, and it is interesting to note that whereas one of the authors has subsequently argued that the approach used tends to mystify social factors (Swartz, 1985b; Swartz & Foster, 1984), another of the authors has claimed that the approach offers useful information on cultural difference (Gillis, 1984). This indicates the extent to which the data presented is open to a range of interpretations and is not value-neutral.

'Westernization', urbanization, and 'sociocultural transition' are often mentioned as stress factors in South Africa (Cheetham & Griffiths, 1982a; Holdstock & Franks, n.d.; Le Roux, 1981; Manganyi, 1974). Arguments concerning the stressful effects of change generally conceive of people 'having' one sort of culture and then moving to acquire another, as can be seen in the use of the term 'transculturation' (Edwards, 1983b). The concept of linear culture change (from one state of culture to another) is often presented as value-neutral but the implicit argument is that the process has negative effects. The nature of the balance between negative and positive is made explicit in the 'acculturation/deculturation' distinction suggested by Cheetham et al (1983) in their study of parasuicide amongst Indian (Asian) people in Durban:

Acculturation can be defined as the adoption of a culture other than the traditional one by virtue of the proximity of a minority group living within the bounds of a majority group the cultural norms of which are at variance with the minority group. This usually applies when the minority group is less sophisticated or developed. Asians, however, already have a sophisticated traditional culture and the influence of urbanization in the Western context represents a deviation from or loss of identification with their basic culture. This could be regarded as deculturation.
(Cheetham et al, 1983, p. 943).

The implication of this quotation is that whereas Indians have a 'sophisticated traditional culture' to lose, others (Blacks, presumably) do not. The concept of gain and loss of culture is in itself simplistic even without this evaluative component. Cheetham et al found in their study that of 100 parasuicides, 54 had had 'precipitating cultural factors' (p. 944) which include cross-caste marriage, romantic or sexual attachments, parental disapproval of such attachments or cross-caste friendships, or a combination of these. The authors argue that this finding reflects 'the stresses of the transitional state of the community' (p. 942), indicating an inferential leap from the data (which are presented in the absence of comparative figures for non-parasuicides) to statements about the 'loss of a culture' in an entire community. The study is based on findings published earlier (Edwards et al, 1981) which contain information about life events not immediately recognizable as 'cultural' but potentially useful clinically (e.g. 58 of the 100 parasuicides had consulted a medical practitioner within the 3 months prior to the episode). The choice of the authors to focus

almost exclusively on 'deculturation' can be viewed as an indirect indication of the strength of such concepts in the literature. A recent study on family functioning in Indian parasuicide patients (Wood & Wassenaar, 1989), similarly, describes these patients and their families as culturally 'transitional' (p. 179), and interprets much of the data in terms of the notion of 'sociocultural transition'. The variable of 'sociocultural transition', however, is not operationally defined nor controlled for nor manipulated. A trend of the same type can be seen in the statement by Ramasuvha (1982, p. 880) on rural Blacks that 'the incidence of emotional stress is definitely lower than in his urbanized counterpart'. No evidence is presented for this firm statement apart from an indirect reference to changing patterns of apparently stress-related disorders. The statement also reflects a possible tendency to refer to all urban Blacks as 'urbanized', thus implying stressful change to exist even in Blacks who have lived in towns all their lives (Swartz, 1985b).

B. Stress, alcoholism and psychosomatic disorder

There is no question that rates of physical disease differ in different population groups, and it is also generally accepted that patterns of prevalence and presentation are changing (Campbell et al, 1982; Van Rensburg & Mans, 1982; Walker, 1982; Wilson & Westcott, 1980). A full review of comparative rates of 'psychosomatic' disorder is beyond the scope of this chapter, but brief attention will be given to those disorders, including alcoholism, which can most directly be seen to have relevance to the cross-cultural study of stress. The list presented, therefore, is not by any means exhaustive, but represents areas in which work most relevant to this review has been done. Emphasis in presentation will, as in the rest of the review, be on method and theory, rather than on findings.

1. Alcoholism

Psychosocial stress has directly or indirectly been held responsible for high rates of alcoholism found in various South African communities (Ben-Arie et al, 1983; Gillis et al, 1965; Gillis & Stone, 1977; McCabe, 1982). McCabe (1982) has related the large amount

of alcoholism seen amongst Blacks in a general hospital to rapidly changing lifestyles, thus invoking the 'change as stress' construct. Alcohol consumption in South Africa is, however, subject to a wide range of changing laws and social practices (McCabe, 1982; Van der Burgh, 1983b) and cannot be understood simply in terms of a single construct. Amongst the coloured community in particular, for example, the 'dop' system (the practice of paying farm labourers in part with alcohol) is likely to have contributed to the picture of high rates for this group.

2. Hypertension

Rates of hypertension for Black, coloured, white and Indian South Africans are estimated respectively at 12.9, 14.9, 21.6 and 31.8 per 100,000. The rate for Indians is thus very high indeed, and deaths caused by hypertension in this group occur at roughly 2.5 times the rate for whites (Van Rensburg & Mans, 1982, p. 115). Malignant hypertension has been identified as costly in terms of health services (Opie, 1988), and an important source of morbidity in Black South Africans (Milne et al, 1989).

Seedat and his colleagues have conducted numerous studies into hypertension, especially amongst Indian and Zulu South Africans (Seedat, 1982a, 1982b; Seedat et al, 1978, 1982). They quote factors such as religion, urbanization and diet as being implicated in different patterns, but they do not consider stress in any great detail. Christodolou (1983), in a correlational study of 40 hypertensive Blacks without any control group, argued for factors such as inability to express anger, intellectualization and changing values in the aetiology of the condition. Venter (1977) found coloured female hypertensives to be more introverted and inhibited than normals, and found a significant correlation between 'inhibition' and blood pressure. Elk and Nash (1985) report an association between hypertension and psychiatric symptoms of anxiety and depression in an elderly coloured community. The question of an association between urbanisation and hypertension in Blacks has been raised, but actual findings appear conflicting (Botha, 1985; Els, 1984). Myers et al (1982) report a prevalence rate of 43.9% of hypertension in semi-skilled coloured and Black

workers, with a higher prevalence amongst those who had done a day's shift when assessed as opposed to those assessed prior to work. They advance the hypothesis that hypertension is related to stress resulting from such factors as repetitive but dangerous work with long hours and inadequate rest periods, coupled with lack of say in decision-making affecting the subjects' own lives. For example, until shortly before the study, double shifts (16 hours per day) were compulsory for the workers at peak times and even with the recent advent of unionization it was difficult for workers to refuse double shifts. Myers et al not only present an intricate argument linking theory to daily lived reality and its hypothesized relationship to hypertension, but they also represent the attempt in South Africa to consider issues of worker stress (cf. Myers, 1984). A notable feature of their approach is that it is parsimonious and does not require recourse to global statements on the nature of 'culture' (cf Turton, 1986b). Other South African work on job stress amongst workers varies on this issue from less 'cultural' (Hobbs, 1981; Nzimande, 1983) to more (Coldwell, 1977; White, 1982), a continuum which to some extent reflects differences in ideological orientation.

3. Duodenal ulceration and gastrointestinal problems

Duodenal ulcer is thought to be increasing rapidly in prevalence among Black migrant workers, and has also been the source of some debate (Blumberg, 1983; Moshal, 1984). In an argument similar to that put forward by Coldwell (1977) about worker stress, Blumberg (1983) conceives of the Black migrant worker as a 'marginal man' between his own culture and that in which he comes to work. Segal and his colleagues have also related duodenal ulcer and irritable bowel syndrome in Blacks to urbanization (Segal et al, 1978; Segal & Hunt, 1975). They argue, however, that the status of stress and anxiety as a means of explaining the increase in such symptoms, is unclear. Segal and Ou Tim (1979) also note the potentially negative effects of herbal remedies prescribed by indigenous healers for gastrointestinal problems. Levin et al (1981) found that stressful situations had been experienced by 71% of their sample of Black and Indian patients with duodenal ulceration

as opposed to 24% of controls, and also found that roughly half of the patients had 'approach avoidance conflict' and 'a compliant personality'. The same team (Schlebusch et al, 1981) found no association between duodenal ulceration and intelligence or depression in what appears to be a subsample of the original study group. Moshal et al (1979) related precipitation of gastrointestinal disease in 522 Black and Indian patients to lack of control over others, and in the case of Indian men to stresses associated with social changes owing to work mobility. Mason et al (1981) found an association between life events, particularly those related to with family problems, and rapidity of healing in Black and Indian patients. In contrast to these studies, Erasmus (1978) discusses duodenal ulceration in two Black female adolescents, relating the condition to 'problems with the mother figure' as assessed by the Rorschach. This study, however, represents an unusual perspective in the literature, with most authors supporting either the 'change as stress' hypothesis or the 'inability to express feelings as stress' hypothesis, or both.

4. Coronary heart disease

The enormous discrepancy between rates of coronary heart disease (CHD) in Black and white South Africans has attracted considerable interest. White South African males in the 30 - 50 year age group have the highest mortality rate from CHD anywhere in the world, and by contrast the condition is extremely rare in Blacks (Seftel, 1978; Van Rensburg & Mans, 1982). The large quantity of work on such issues as the Type A personality in white South Africans will not be discussed here. However, of relevance to this chapter is the widely-held view that as people move into the cities, the diseases associated with urban lifestyle (such as CHD) increase (Seftel, 1977). Increases in rates of CHD amongst Blacks are therefore not unexpected. However, the type of CHD observed among Blacks may not be that generally related to the often-mentioned Western lifestyle and living standard. Instead, it seems that the most prominent cardiac disorders seen in Blacks (urban or rural) are rheumatoid heart disease, beriberi-cardiac myopathy and idiopathic congestive cardiac

myopathy (Van Rensburg & Mans, 1982, p. 110). According to Van Rensburg and Mans, who summarize original articles on the subject:

the two last-mentioned conditions are usually the result of chronic malnutrition or excessive consumption of alcohol. This particular combination... is usually found in Black migrant labourers or manual labourers living in hostel-type accommodation, and can mainly be ascribed to problems arising from living without a wife and having to make do with limited amenities and facilities, including those required for the preparation of an adequate diet. (Van Rensburg & Mans, 1982, p. 110).

The importance of this argument for the present discussion, regardless in fact of whether it is correct or not, lies in its demonstration that the concept of stress should not be seen as a desocialized entity divorced from economic and sociopolitical factors. It is noteworthy that a comprehensive psychological theory to account for the supposed increase in psychosomatic disorder in urban Blacks in particular in South Africa has not been advanced. Psychiatric work in the field of psychosomatics and culture is still comparatively rare, but analyses of the kind proposed by Myers et al (1982) in the field of hypertension point the way to further research.

V. Concluding comments

The review presented in this chapter has been, as was stated in the introduction, necessarily superficial, but sufficient for the drawing out of certain key trends.

A dualistic perspective, with whites inhabiting one 'world' and Blacks another, is pervasive. Even where the concept of cultural change is allowed for, further dualisms tend to be set up - between the 'traditional' and the 'modern' or 'Westernised' Black, for example, and between the rural and the urban Black. As the South African stress literature shows, 'Westernisation', 'modernity', and 'acculturation' are almost invariably seen as pathogenic in some respect, and a rupture from the true and 'natural' place of Black people (cf. Swartz, 1985b; Swartz et al, in press). The concept of the 'natural' Black may be related to a reified essentialist view of culture, which views culture as an entity which is immutable and resides

within people (Sharp, 1980)¹⁴. The implications of this view, and related debates, are considered more fully in Chapter 4.

The literature review reveals that little attention is given to sociopolitical factors, and that there is scant mention made of the fact that in using the concept of culture in South Africa one is willy-nilly raising the issue of the concept of culture as a tool of political oppression. This is so regardless of the orientation of the particular author. The issues of culture and politics are inextricably linked wherever they are raised (Littlewood & Lipsedge, 1989; Scheper-Hughes & Lock, 1987); the link takes on a particular importance in the South African context. The following chapter, on apartheid and mental health, considers this issue in more detail.

Notes to Chapter 2

1. The word 'key' in itself, of course, implies a construction. What my approach may define as 'key' may not be defined so by others.
2. For a history of South African mental health services, see Minde, 1974a - d, 1975a - h, 1976, 1977a - b. Minde's approach to development in the South African mental health field is based on an essentially progressivist view of history which assumes that all changes in mental health services can be related to improvements in facilities and the increasing knowledge of medical science. Moyle's (1987) early history of Valkenberg Hospital is more interesting methodologically as it raises the question of how racist ideology came to penetrate the language and practice of psychiatric care in South Africa.
3. I use the terms coloured, Black, Indian and white in accordance with official South African policy. This does not imply that I accept that the categories have status as any more than legal labels. Throughout this dissertation I use the labels as they appear in the Population Registration Act of 1950 as amended (i. e. 'Black' and 'Indian' capitalised, 'white' and 'coloured' with lower case leading characters). The use of a capital letter for 'Indian' is self-explanatory, although there are South Africans opposed to apartheid who use 'indian'. 'Black' (capitalised) seems to have been developed by historical accident when the official usage changed from 'Bantu' (always capitalised). It is nevertheless an interesting phenomenon, as the retained capital letter may be seen to imply the existence of an essential Black identity - a core concept, as will be seen, in South African transcultural psychiatry. In the rest of this dissertation I use the term 'black' to refer to all South Africans not eligible to vote for candidates in the House of Assembly - i.e. all South Africans not classified 'white'. The term is preferable to the clearly racist 'non-white'. Where the term 'black' is used at the beginning of a sentence I differentiate it in parenthesis from 'Black' in the narrower sense, which is my more frequent usage.

I have not followed government policy in considering the recently created 'national states' (homelands, Bantustans) of Transkei, Ciskei, Bophuthatswana and Venda as separate and independent from South Africa, and I treat them as an integral part of the country.

4. Littlewood (in press) reviews some of the terms which have been used to define the field internationally. I have decided to use the term 'transcultural psychiatry' as particularly since Kleinman's (1977) article differentiating the 'old transcultural psychiatry' from the 'new cross-cultural psychiatry' the term has tended to be associated, amongst many other things with a practice which is not self-critical and reflexive. On the whole (though this is the grossest of generalisations), this tends to hold for the South African literature.
5. This is my translation of the Afrikaans:

Die Westerse wêreld waarin die hedendaagse Swarte beweeg, beklemtoon die individu, die tegnologie, die wetenskap, die geldeconomie en die sosiale filosofie van 'n mededingende gemeenskap vir wie die tyd van besondere belang is....

In teenstelling hiermee belewe die Swartman in 'n groot mate 'n statiese lewenspatroon. Waardes en norme is hoofsaaklik stam- en familiegebonde en onderrig is alleen gerig op groepsolidariteit en gesanksioneerde gedragspatrone.

Dit is dus begryplik dat die moderne Swartman, as gevolg van sy tradisionele wortels 'vasgevang' is en gevolglik selde die moed en inisiatief openbaar om vrylik die wêreld te eksploreer en hom op terreine buite sy bekendheidsfeer te waag.

(Carstens, 1985, pp. 15-16).

6. The appeal of the concept of the extended family's necessarily offering support of a 'traditional' kind can be seen through an examination of De Bruyn's (1985) study entitled *The role of the Indian woman*. In an introductory section on the 'role context of the Indian woman' de Bruyn has a subheading entitled 'the extended family' (p. 32). Under this subheading De Bruyn briefly cites research which claims that the family is a primary source of socialisation and support for all people (pp. 32-33). No mention is

made of the extended family or of ways in which the nuclear family and extended family compare on these dimensions. One can assume, however, that De Bruyn's implication, in the absence of any evidence, is that the extended family is superior to the nuclear family. This assumption seems justified at least in part by De Bruyn's claim made later in the study that the 'collapse of the extended family under Western culture' (p. 95 - the violent metaphor is evocative) leads to a loss of the 'most important source of guidance and support' (p. 95). No data is presented as a basis for this claim. Whether the claim is 'true' or not, the fact that the concept of the 'traditional extended family' is so unproblematised suggests that the value of this family is accepted by De Bruyn as self-evident.

7. It is not irrelevant to the current discussion that Jung's theories have been argued to be racist (Dalal, 1988).
8. *Ufufunyane* (the plural form, *amafufunyane*, is also used) has been defined as a 'rapidly spreading disease which causes delirium and insecurity; type of brain disease, manic, hysteria' (Ngubane, 1977, p. 144). The condition is similar to *amok* in that it is potentially extremely disruptive socially, and as such it provides a useful focus for arguments about the social function of disorder.
9. My translation of the Afrikaans 'tradisionele swart Suid-Afrikaners' - the words which appear in the title of the chapter in question. The chapter appears in what is to my knowledge, the only South African textbook on abnormal behaviour apart from Gillis's (1986a) brief handbook marketed for undergraduate medical students, and Nash et al's (1984) textbook on human behaviour, which also considers aspects of abnormal behaviour.
10. This is my translation of the Afrikaans: 'In die algemeen word aanvaar dat siektes wat deur die voorouers of deur die hekse gestuur word of deur besmetting teweeggebring is, nie binne die Westerse sisteem behandel kan word nie, en dit is eers wanneer tradisionele behandelings onsuksesvol is, dat van Westerse dienste gebruik maak word.' (Schoeman, 1989, p. 470).
11. My translation of: 'Die keuse is gewoonlik die gevolg van die pasiënt se spesifieke interpretasie van sy siekte.' (Schoeman, 1989, p. 470).
12. It is interesting to note here that the belief that world-view determines choice of healer can be related to a very particular local interpretation of well-known international research, such as that of Janzen (1978) which examines factors affecting choice of healer. In the local context, sociopolitical determinants in health care provision tend to be ignored or at best given scant attention when questions of 'culture' arise. I deal more specifically with the question of local realisations of key international debates in cross-cultural psychiatry in Chapter 4.
13. The same material is presented by Edwards (1986).
14. It is interesting that two authors who problematise the issue of culture and do not fall into the trap of reification both concern themselves with political factors in social change in South Africa (Freeman, 1984; Gilbert, 1986).

Chapter 3

Apartheid and mental health

Table of contents

I.	Introduction	57
II.	Apartheid and mental health care	58
	A. Health care policy and practice in South Africa	58
	B. Mental health services	61
III.	Does apartheid cause mental illness?	64
IV.	Apartheid and the production of knowledge about mental health	69
V.	The South African psychiatrist in relation to apartheid	71
	A. Descriptions of apartheid psychiatry and psychiatrists	71
	B. Professional and alternative organisations	74
VI.	Concluding comments	77
	Notes	79

Chapter 3

Apartheid and mental health

I. Introduction

There is a serious problem with considering the topic of apartheid and mental health in a separate chapter from the review of transcultural psychiatry. The special category may give the false impression that ideological questions are separate from some issues in transcultural psychiatry. My choice of the word 'apartheid' in this section is also problematic, firstly as this is no longer the official term for government policy and secondly as the roots of the present system predate the accession to power of the architects of formal apartheid policy in 1948. However, the term provides a convenient and well-known shorthand for a system of legally enforced discrimination on the basis of colour ('culture', 'ethnicity', 'national sovereignty'). In spite of much-publicized reforms and changes in what Posel (1984) has termed the 'language of legitimation' this system remains the cornerstone of South African government policy¹. I use the term 'discrimination' as opposed to 'recognition of cultural diversity' as there is ample evidence to demonstrate unequal facilities, services and opportunities for South Africans of different 'cultural' groups (South African Institute of Race Relations, 1988).

The question of the (hypothesised) relationship between apartheid and mental health is complex and cannot be dealt with fully in a single chapter. It is however crucial to this dissertation that key issues about the relationship be considered and explored. For purposes of brief discussion, the relationship between apartheid and mental health can be considered under four headings, which clearly overlap. They are

1. Apartheid and mental health care
2. Does apartheid cause mental illness?
3. Apartheid and the production of knowledge about mental health, and
4. The South African psychiatrist in relation to apartheid.

Each of these areas is enormously complex, and just a few points will be sketched here.

II. Apartheid and mental health care

A. Health care policy and practice in South Africa

Any discussion of mental health care in South Africa must be viewed within the context of health care policy in general (De Beer, 1984). The bureaucracies involved in health and welfare services are enormously complex, and I cannot within the space available hope to do more than provide a brief outline of some of the key issues in health care provision in this country.

The South African health care system is fragmented along 'ethnic' lines. The concept of each 'ethnic' group having its own health service leads to the bureaucratic extravagance of fourteen health departments in one country (De Beer, 1984). It can also result in patients' using facilities far away from their homes, as facilities near them are for other groups. If, for example, a Black person lives across the road from a 'white' hospital, that person must go for treatment to a 'Black' hospital, often many kilometres away². The political abuse of concepts of culture and ethnicity go even further, though, when the construction of the 'homelands' (National states, Bantustans) is considered. As a result of the creation of such 'independent' or 'self-governing' states it has now become possible for a Black person living in a rural area and designated as belonging to a certain tribe to be restricted in access to health care facilities close to his/her home because such facilities are now deemed to be situated in a 'foreign' state - land allocated to members of another Black tribe/ethnic group/culture (De Beer 1986). Price et al (1985) point out that the 'homeland' (Bantustan) health services contribute to wasted resources, lack of coordination, creation of ethnic divisions and consciousness, diffusion of responsibility for health care, and continuing actual dependence of these systems on the South African state (see also Turshen, 1986). The fragmentation of health services extends beyond the issue of

homeland health care, though, and even beyond the question of services specifically for Blacks. The current South African constitution (which has been in operation for five years) makes a distinction between what it terms 'general affairs' and 'own affairs'. Matters under 'general affairs' are those which supposedly are common to all South Africans, such as national defence, and those under 'own affairs' are specific to specific population groups. Health has been deemed by the constitution to be an 'own affair', with the result that there are even separate health departments, with separate budgets and inevitable duplication of administrative structures, for whites, coloureds and Indians.

It is important to note for purposes of this discussion that the concept of 'culture' as used by the South African state is fundamental to such absurd practices and to the consequences of poorer standards of health care and greater problems of access to care (Thornton, 1988). Another concept which is also abused by the state in this context is that of 'community'; services are supposedly designed to be community-specific and community-sensitive. This is, in fact, a gloss for inequalities, and also for defining people not by reference even to geographical location, which could arguably make sense in community health planning, but by reliance on definitions of difference which form the cornerstone of South African apartheid policy - the Population Registration Act (Thornton & Ramphele, 1988).

The inextricable relationship between social and political conditions in South Africa and disparities in health services and indices of health has been amply demonstrated (Andersson & Marks, 1988; Botha et al, 1988; Seedat, 1984; Van Rensburg & Mans, 1982; Wilson & Westcott, 1980; Zwi, 1987; Zwi & Saunders, 1986). Particular areas of concern include the epidemiology of tuberculosis, which is primarily a disease of poverty (Yach, 1988); the area of occupational health and the implications of worksite exploitation for health status (Myers et al, 1982; Zwi, Fonn, & Steinberg, 1988), and continuing developments in state strategies and policies which impact on health (Andersson & Marks, 1988; Zwi, Marks, & Andersson, 1988). In line with other aspects of current state policy, privatisation of health services is high on the state's list of priorities, a fact which almost

certainly will make health services even less accessible to the mass of poor, Black South Africans (Naylor, 1988; Price, 1988; Zwarenstein & Bradshaw, 1989). In this regard, there has been considerable discussion of late in anti-government medical circles of the prospects for a national health system which would not discriminate on the grounds of race, 'culture', or socioeconomic position (Owen, 1987, 1989).

An issue which has attracted considerable debate both inside South Africa and internationally has been the moral culpability of South African personnel in participating in a discriminatory health system (Seedat, 1984; Wilson, & Westcott 1980). A key focus in this concern has been the death in detention of the activist Steve Biko in 1977. The district surgeons who examined Biko shortly before his death from head injuries sustained, it must be assumed, at the hands of his captors, failed to intervene and in fact gave permission for this seriously neurologically impaired man to be transported a distance of some 1000km in the back of a police van (Seedat, 1984, pp. 97-98). Both the statutory South African Medical and Dental Council, and the Medical Association of South Africa (MASA), to which most South African medical practitioners belong, were extremely tardy and to all appearances reluctant in censuring the doctors concerned (Rayner, 1987). The affair led some progressive medical practitioners to set up the National Medical and Dental Association (NAMDA), an organisation committed to equality in health care and accountability to all South Africans. Psychiatry has received special attention as a discipline in which the questions of professional ethics and morality have been discussed. The entire question of culpability will be considered in greater length with respect to psychiatry towards the end of this chapter.

As mentioned at the outset of this section, it is impossible to do full justice to the issue of the relationship between apartheid and health services in the space available. What has been mentioned here serves purely as a sketched context for more specific discussion of mental health care below. It is worth noting here however that only comparatively recently have explicit attempts been made to relate questions regarding the political economy of

mental health in South Africa to broader health issues in the country (Dawes, 1985; Dommisse, 1986; Vogelmann, 1986).

B. Mental health services

The World Health Organization's preliminary document on apartheid and mental health care (1977) presents a clear picture of differences between psychiatric facilities for whites and those for other South Africans. In spite of differences of opinion as to the accuracy of some of the claims made (Gillis, 1977, 1978; Jablensky, 1978; *The Lancet*, 1977), the inequalities in facilities are undisputed. Solomons (1980) has provided a detailed historical perspective of the development of these unequal facilities. Dovey (1983) has demonstrated that guidance and counselling facilities are similarly affected by apartheid.

The American Psychiatric Association (APA) Committee to Visit South Africa (Stone et al, 1979), focussing chiefly but not solely on privately-run psychiatric institutions in South Africa, confirms much of the WHO report. Large discrepancies between monies spent on white and other patients in these institutions were recorded. The APA committee failed to find evidence for psychiatric incarceration of anti-government activists, but reported inadequacies of care in almost all areas, including basic medical care of Black patients in certain institutions. The South African Department of Health disputed many of the findings (Stone, et al, 1979). An interesting feature of some of the Department of Health's objections to the opinions of the Committee to Visit South Africa is that 'culture' was used in defence of what the Committee saw as discriminatory practices. For example, the Committee reported that they observed that patients on the 'black' side of a psychiatric hospital received inferior food from that provided for whites on the other side of the same institution, and that many black patients were poorly clothed and without shoes. The response of the Department of Health was that culturally black patients do not like Western food, and that they do not like wearing shoes in summer³. It should be noted that the black side of the hospital concerned catered at that time for coloured as well as Black

patients. The category 'coloured' is simply a rag-bag (the Population Registration Act defines a coloured person as anyone who is neither white nor Black) and the 'cultural' argument is particularly specious when applied to coloured people (Patterson, 1989)⁴. A further interesting fact is that within a few years of the Committee's visit, patients on the black side of the hospital concerned could be seen to be wearing shoes throughout the year and to be receiving the same food as served on the white side. Clearly, their 'culture' as understood in the ahistorical essentialist sense outlined in the previous chapter could not have changed, and it is more than likely that the opinions of the Committee were being responded to. If this is the case, one need go no further for evidence in the psychiatric context of the concept 'culture' in use as a political smokescreen.

As is the case with health services in general, as mentioned previously, mental health services have become even more fragmented than they were previously, since the advent of the new tricameral constitutional system. Commenting on the complexity of mental health service structures, Freeman (1989b) writes:

...the main reason for the confusion of so many, is a mental health structure the logic of which seems to require either complex technical skill or a slightly twisted intellect to fathom - I fear its (*sic*) the latter. What depressed me though was not the complexity of the structure itself, but that care is prejudiced as a result of the political motives which underlie mental health care structures.
(Freeman, 1989b, p. 1).

A graphic example of the effects of political fragmentation is that prior to the current constitutional system in South Africa there were nine regional welfare boards, but 'there are now 25 racially separate boards ostensibly each catering for the future of their "own" communities' (Freeman, 1989a, p. 2). Fragmentation affects the services provided even to individual patients:

Tinswalo Hospital, sited in Gazankulu [a 'homeland'], provides in-patient care for patients from the surrounding region which includes Lebowa [another 'homeland'] and 'white' South Africa, irrespective of their 'citizenship'. However, community services are restricted to Gazankulu citizens and Lebowans discharged from Tintswalo Hospital are expected to seek follow-up community care from their own health services in Lebowa.
(Freeman, 1989a, p. 4).

Every aspect of mental health care is affected by apartheid. The mere fact of segregation of facilities by race has serious implications. In Johannesburg community psychiatric services, one medical practitioner or psychiatrist sees between 25 and 50 Black patients in one morning at a clinic, but at the equivalent 'white' service, between 20 and 30 patients are seen (Freeman, 1989a, p. 10). The maximum disability grant for Blacks is R150 per month, R200 for coloureds and Indians, and R251 for whites (Freeman, 1989a, p. 10). Overcrowding of facilities is the rule for Blacks but not for whites - 2,679 Black male patients in institutions with an official bed capacity of 2,193 in 1985; for white males there were 271 beds officially empty on the same day (calculated from Freeman, 1989a, p. 11). The ratio of number of psychiatric beds to population in Johannesburg is approximately 1:6,300 for Blacks, and 1:2,500 for whites (calculated from Freeman, 1989a, pp. 11-12), with a range of sophisticated services available to whites which are not available to Blacks. In every respect, and in spite of state claims of liberalisation, Blacks are grossly discriminated against. Freeman (1989a) points out further that imminent privatisation of mental health services will inevitably make things worse for poor (i. e. Black) patients.

International concern about the role of apartheid in mental health care has been expressed by a number of authors (e.g. Dommisse, 1984a, 1986; Pillay, 1984; Sashidharan, 1981) including those specifically concerned with transcultural psychiatry (Sashidharan et al, 1982), with much of the debate's being cast in moral terms. It is true that following international pressure (though some would say not as a result of it) there have been some changes in the provision of facilities for all mentally ill South Africans. One potential problem, however, is the extent to which useful innovations can be effectively appropriated into a system which is structurally inimical to change. Savage (1979) among many others has demonstrated the obstacles which stand in the way of providing adequate medical care in South Africa, and Hammond and Buch (1984) have raised the issue of how even a progressive concept such as the use of community health workers may be, as they put it, 'perverted' such that inferior services are offered. The move within psychiatry to

collaborate with 'traditional healers' discussed in the previous chapter is similarly problematic. Recognition of the value of indigenous healing may well be progressive and enlightened, but the suggestion for psychiatry to form a partnership with such healers (Robbertze, 1980) can be evaluated only within two contexts: firstly, the proposed inequality of the relationship; and secondly, gross disparities in medical care in South Africa. A question that can be raised is that of whether 'traditional healers' are being feted because of their ability to ease the workload of a system which in other areas is a world leader in expensive medical care (such as organ transplants) (Odejide et al, 1989). I am not arguing that proponents of such ventures are acting in bad faith (quite the contrary, in many cases), but the issue of whether living in South Africa leads one simply to accept certain discriminatory ways of thinking and practice as 'natural' is a crucial one, and one with which Part 3 of this dissertation is implicitly concerned.

III. Does apartheid cause mental illness?

Two books entitled *The psychology of apartheid* and written by psychologists who had lived and worked in South Africa have sought to pin a psychiatric diagnosis on South African society. Van der Spuy (in Van der Spuy & Shamley, 1978) has referred to Afrikaners' 'authoritarianism', 'obsessionality' and 'emotional immaturity'; Lambley (1980, pp. 251-252) refers to the 'sociopathic Afrikaner community' and says that 'South Africa as it is today is a mentally deranged society'. Lambley's accounts of his difficulties as a clinical psychologist working in South Africa are evocative, but both he and Van der Spuy make leaps from psychometric test data to 'cultural diagnosis' which are unfortunate for at least two reasons. Firstly, it is simplistic to argue that a 'neurotic apartheid society' somehow 'causes' high MMPI anxiety scores, for example. Neither author provides adequate discussion of proposed mechanisms of causation or of the possible methodological weaknesses of the psychometric approach. Secondly, and this is more serious, both authors reduce a complex political system to a set of psychiatric labels. Van der Spuy goes so far as to suggest psychotherapy on a grand scale as a palliative - this is clearly politically naïve.

It is of course almost impossible methodologically to prove that a given political system, however extreme or barbaric, causes mental illness (Hayes, 1983). Even firm figures such as those for suicide are difficult to link to apartheid directly (Meer, 1976). Attempts to relate apartheid to mental illness have generally been indirect. For example, Manganyi (1970) found no differences in body image between paraplegic and normal Blacks and uses this information to theorize about the general psychological ill-health of the group (1973, 1977). This argument does not give due credence, however, to the possible methodological flaws in the original study, and Couve (1984, 1986) has suggested that Manganyi may lack a degree of theoretical precision in this work. However, Manganyi does provide graphic descriptions of emotional life under apartheid, and the basis for the development of a local psychology of oppression on Fanonesque lines (Fanon, 1965).

The psychology of apartheid is of course not simply the psychology of a supposedly 'sick society' but is the psychology of oppression, violence, detention without trial, forced removals, separation of families, huge disparities in income, nutrition and health care, to name just some everyday features of South African life. Official policy on many of the harsher features of apartheid legislation has changed, but the extent to which practices have changed in reality is debatable.

There can be no doubt that apartheid is implicated in health disparities, as suggested earlier. According to the South African Institute of Race Relations (SAIRR, 1985), the mortality rate per 1 000 white births in 1982 was 13.4, and in the same year the figures for Indians, coloureds and Blacks were 20.7, 59.2 and 80 respectively (p. 723). UNICEF (quoted by the SAIRR, 1984), reports that South Africa has one of the highest infant mortality rates in relation to national wealth in the world (along with countries such as Brazil, Oman and Saudi Arabia).

Numerous other factors potentially associated with health status are affected by apartheid, and the statistics which follow give a mere indication of the whole picture.

Forced removals. By the end of 1982, 2,285 white, 81,948 coloured and 39,485 Indian families had been moved under the auspices of the Group Areas Act of 1950 which legislates that neighbourhoods must be 'racially' homogeneous (SAIRR, 1984, p. 233). Official figures placed forced removals of Blacks in 1983 at 28,796, roughly 4,000 up from each of the previous two years (SAIRR, 1985, p 487). In spite of official relaxation of policy regarding forced removals, in 1986 this figure had rocketed to 64,180 (SAIRR, 1988, p. 1). The Surplus People Project has estimated that 3,522,900 South Africans of all races had been moved between 1960 and 1982 - a figure which has been disputed by the authorities (SAIRR, 1985, p 487).

Pass laws. In 1983 alone 262,094 Blacks were arrested under the pass laws by which all Blacks were required to carry an 'Identity Document'. This figure was 28 percent up from that for 1982, which was in turn 28 percent higher than the 1981 figure (SAIRR, 1985, p. 348). The carrying of passes was instituted in an attempt to stem the influx of Blacks into 'white', urban areas. Influx control was abolished in 1986, and the Minister of Law and Order at the time stated that 17 million people had been arrested while the laws had been in force (SAIRR, 1988, p. 460). In spite of abolition of influx control and a switch to a policy recognising the inevitability of urbanisation, the state has been seen to use other legislation for the same purpose as influx control. In 1986, for example, 77,458 Blacks had been arrested for trespassing - an average of 212 per day (SAIRR, 1988, p. 461).

Detentions. Detentions without trial in South Africa have increased dramatically, with a peak being reached in 1985-6. Detentions under the provisions of the Internal Security Act rocketed from 505 in 1984 to 2,387 in 1985, a change of 427 percent. Of all those detained under these provisions in 1985, 6 percent were charged with any offence, and just over 1 percent (30) convicted (Repression Monitoring Group) (RMG), 1986a). In the first three months of the 1986 State of Emergency, conservative estimates placed the number of detentions under emergency regulations at roughly 14,000, almost three times the figure of 5,196 recorded for three months of the 1985 emergency (RMG, 1986c). Between 1 January

and 15 April 1987, 19,209 people had been detained, according to official figures, and the Detainees Parents Support Committee estimated that 25,000 people were detained under emergency regulations between 12 June 1986 and 11 June 1987, and that on any single day there were approximately 5,000 people in detention (SAIRR, 1988, pp. 536-537). In October 1986 the eighty-second South African, as far as is known, died in political custody (RMG, 1986e). The area of detention of children has caused particular concern (Swartz & Levett, 1989). The Minister of Law and Order admitted in parliament in February 1988 that 1,388 people under the age of eighteen had been detained under emergency regulations in 1987 (SAIRR, 1988, p. 538). In a study of 176 ex-detainees, Foster et al (1987) found that 83 percent claimed to have been subjected to some form of physical abuse, with widespread use of a range of physical and psychological torture methods. Eighty-three percent of ex-detainees treated by a group of Johannesburg doctors had been physically abused, a figure which accords with those of Foster et al (Browde, 1988; RMG, 1986d).

Violence. Not only detainees are affected by the turmoil in the country. Militarization is having effects even on the relatively protected white community (Cock & Nathan, 1989; Feinstein et al, 1986). Five weeks of the most violent State of Emergency to date (12 June - 18 July, 1986) yielded a figure of 158 'unrest-related' deaths (RMG, 1986b). Through vigilante action, which many eye-witness reports state was supported by South African security police, more than 70,000 people living in squatter communities lost their homes and possessions (Grassroots, 1986). Dawes et al (1989) have demonstrated psychological symptoms in response to this violent disruption.

The ultimate effects of these and other more chronic situations on mental health in South Africa are incalculable. Studies of both the acute and less obvious features of apartheid society and mental health are needed, and those that are available are telling. For example, Stoch et al (1982) in a 20-year follow up study of severely under-nourished coloured infants, demonstrated differences between the index groups and well-nourished controls on IQ, physical size, and a variety of other factors. Their finding that the

malnourished group were as well integrated into the community as controls, suggests a series of questions about the research methodology, the ability of the community to tolerate deviance, the prevalence of malnutrition-based disorders in South Africa, and many more. Looking at acute factors, Skinner & Swartz (1989) found widespread adjustment reactions in a sample of 19 pre-school children of detainees.

There can be no question that the South African situation contains many features which are universally thought to be pathogenic, as has been seen. It also includes the added factor of apartheid ideology. Even if one accepts, however, that this ideology has structural similarities to and historical links with Nazism (Dommissie, 1984b), there may be problems with trying to demonstrate a direct link between apartheid and mental illness. The assumption that serious injustices in a political system must be visible in the psychological functioning of individuals fails to take account of mechanisms that communities may use to deal with oppression. A potential danger in the arguments attempting to link mental illness directly to apartheid may be that evidence of relative mental health in some areas may be taken, conversely, to defend the apartheid system. It is a very different matter to attribute malnutrition rates to apartheid than it is to attribute rates of psychiatric disorder to the system. Attempts to set up direct links of this kind may hinder rather than help efforts to demonstrate the complex role of apartheid in mental illness. Victimological discourse, furthermore, in discussions of the effects of apartheid, may paradoxically create an image of passivity and helplessness in victims as opposed to fostering empowerment of oppressed groups (Lab, 1988; Straker, 1988; Swartz & Levett, 1989; Swartz et al, in press).

This having been said, though, it needs to be emphasized that there can be no question that apartheid experiences must form a crucial part of the developmental history of every South African, and to ignore this factor in any theory of mental health and illness is likely to render the theory decontextualized and unsatisfactory. It should also be noted that much of the literature choosing to isolate 'culture' as a primary explanatory concept suffers from a naïvely linear model of illness causation no less problematic than would be a linear

causation model using 'apartheid' as the cause. This observation raises the issue of what constitutes a viable research framework to study mental health issues in South Africa. This question will be dealt with to some extent in the following section.

IV. Apartheid and the production of knowledge about mental health

A recent South African medical text-book contains a chapter on psychiatric illness, the second paragraph of which reads:

For the urbanized Black it is true that the 'tradition-directed personality' has disappeared, whilst the 'inner directed personality' has failed to appear. They therefore find themselves in a psychic turmoil, which expresses itself in an increasing incidence of psychiatric problems of a psychosomatic nature, as well as anxiety, depression and alcoholic addictions. (Henning, 1982, p. 445).

The fact that this statement is made without supporting evidence may be explained to an extent by its presence in a basic text aimed at undergraduates, among others. Nevertheless, the bold assertions about the 'facts' of types of personality which can enter, leave or be absent from entire communities suggest that the author is convinced of the veracity of the claims made. The sheer glibness of such assertions must be viewed within the context of the South African academic and professional environment.

A second example of work which demonstrates the influence of apartheid ideology (or racism in general - cf Bulhan, 1981, 1985; Mercer, 1986) on research, is a thesis by Potgieter (1986). The English title of this study is *The work-shy Coloured man: a psychodiagnostic study* (p. 275), and the following quotations are taken from the English summary:

Somebody is regarded as being work-shy [for purposes of being included in the study] if he has been unemployed for six months or longer, is not unfit for work because of illness and is not officially registered as being unemployed. (Potgieter, 1986, p. 276).

A significant difference was found to exist between the intellectual abilities of the work-shy and the steady workers....There is the possibility that the work-shy will give in to the

temptation not to work because of lower intellectual ability, so that this could be a reason for his being work-shy.
(Potgieter, 1986, p. 276).

It should be noted that this study took place at a time when unemployment in South Africa was at extremely high levels, the rate for coloureds being roughly 14% (SAIRR, 1988, p. 294). The definition of people who are not working and not registered as unemployed as 'work-shy' furthermore, is indefensible regardless of unemployment rates. Whatever the myriad methodological flaws of the work, it is interesting from an ideological point of view. The racist image of the lazy coloured person, who chooses not to work, is clearly being reproduced here. The fact that such a piece of work was passed for a masters degree at a South African university is a serious indictment of higher education in this country⁵.

Dawes (1985) has argued that clinical psychology in South Africa does not adequately consider its ideological base and as such fails to provide any serious critique of the *status quo*. Sharp (1980, 1981) and the recent collection edited by Boonzaier and Sharp (1988) have shown that South African anthropology, and notably that subdiscipline known as *volkekunde*, tends, in a particular interpretation of the structural-functionalist tradition, to take the presence of 'ethnic' or 'cultural' categories as *a priori*. A similar phenomenon can be found in transcultural psychiatric studies, in which it is assumed that cultural differences must exist and that it is the job of transcultural psychiatry to see whether or not these extend to psychopathology. Knowledge of expected differences in presentation and illness management is of course clinically invaluable. It is however noteworthy that these differences tend to be located in archaic or simplistic 'essences' (cf. Swartz, 1985b; Swartz & Foster, 1984). Furthermore, discussion of 'culture' as a final mode of explanation in South Africa simultaneously takes as given the scientific validity of legal categories, and suppresses discourse about other factors (see Chapter 4). If, for example, the psychological status of an urban Black can be reduced to a series of characteristics which supposedly inhere in certain aspects of 'acculturating' people, then it is not necessary to look to class factors and consequences of living with inequality for models of explanations.

South African work on transcultural psychiatry does not, of course, always ignore issues of power and inequality, and much of the research produced is undeniably useful. However, the danger of transcultural psychiatry in South Africa is that it can operate from a series of assumptions about the 'otherness' of supposedly discrete groups (see Chapter 4). The strong tendency to focus on the exotic and apparently bizarre (once again, not a purely South African trend) has the potential in this country to set up a particular level of research framework. This approach, by the very nature of the questions it asks, may go some way to legitimate discriminatory and segregationist policies. The concept of 'cultural diversity' cannot be anything but value-laden in South Africa, as it forms the basis of justification for apartheid policies. The challenge for South African work is not to ignore differences where they may exist, but to discuss both common and unusual features within the broad local health and ideological context. To ignore the context may in many cases be to contribute to it. Precisely how to proceed in this regard however, is an extremely difficult question, as will be seen in the following chapter.

V. The South African psychiatrist in relation to apartheid

A. Descriptions of apartheid psychiatry and psychiatrists

Given the documented inequities in psychiatric care, and the exploitation of Black psychiatric patients in some cases (Stone et al, 1979), the question arises as to what sorts of people South African psychiatrists are. How does one explain the fact of participation in discriminatory practices on the part of people whose overt life's work is the alleviation of distress? This is a crucial question which needs to be addressed in any examination of psychiatric culture in South Africa, and one which underlies much of the empirical research in this dissertation.

The most simple answer to the question can be established by pointing to psychiatrists and mental health professionals who are, or are seen to be, ideologues operating quite clearly

in the service of the state and apartheid ideology. By far the most famous and influential psychologist in South Africa's history, for example, was the late Dr H F Verwoerd. It was during his term of office as Prime Minister that the apartheid apparatus, including the Bantustan system, became firmly entrenched, and security legislation (including that for detention without trial) more brutal and repressive than before. Going further back in history, there have been South African psychiatrists, like others in the history of medicine (Fernando, 1988; Littlewood & Lipsedge, 1989), who have viewed blacks almost as members of sub-human species. This is well illustrated by Laubscher's (1937) text on psychopathology amongst Blacks.

There is no question in my mind that there must be a proportion of South African psychiatrists and mental health practitioners who are racist - this much is clear from a reading of the literature. This is probably the case universally, in spite of findings that psychiatrists are generally less racist and more liberal than their non-psychiatric medical colleagues (Light, 1980). What interests me more, largely because of my own experiences in particular areas of South African psychiatry, is the question of how practitioners who clearly see themselves as non-racist and anti-racist - indeed, in some cases as guardians of the future mental health of all South Africans - participate in the reproduction of racist practices, and in the defence of South African psychiatry (Gillis, 1977, 1978; Hemphill, 1987, 1988; cf Edwards, 1987)⁶. These people are commonly on the staff of or are associated with English-speaking universities with strong liberal traditions. The empirical data presented in this dissertation was collected at just such an institution. The underlying question is not whether South African psychiatry is institutionally racist (the answer to this question is clearly 'yes'), or whether all South African psychiatrists and other mental health professionals are racist (the answer to this question is clearly 'no'), but that of how racism is reproduced, to some extent regardless of the overt ideological orientation of the clinicians involved.

The literature on South African psychiatry as reproducer of oppression is inconsistent, and often poorly argued. Publications which quote statistics for discrepancies on spending on mental health services have the advantage of providing empirical evidence for the existence of institutional racism. This is reflected in South Africa's distribution of mental health services, as discussed in a previous section (see also Dommisse, 1987; Fluxman, 1985; Jewkes, 1984). When the issue of culpability for participation by South African psychiatry in racist services is discussed, two major positions emerge. The first of these can be termed the 'embattled' or the 'stressed' position, which argues essentially that South African psychiatry is in a difficult situation and is doing its best to right wrongs (Nightingale & Stover, 1985, p. 247; van der Spuy & Shamley, 1978). The second position is less sympathetic towards South African psychiatrists themselves, and more inclined to apportion blame. This may be termed the 'condemnatory' position (Dommisse, 1987; Fernando, 1988, pp. 180-1; Fluxman, 1985; Lambley, 1980). These two positions can be seen to have different tactics in that proponents of the 'embattled' view tend to advocate support for South African psychiatrists in their attempts to improve the situation, and 'condemnatory' view supporters tend to suggest isolation of South African psychiatry as a strategy for forcing change⁷. The British Psychological Society in a recent resolution appears to be attempting to opt for a middle course between these positions in advocating what amounts to a selective academic boycott which is designed to exclude South Africans supportive of discrimination but not others (BPS, 1989).

Rhetoric about the evils of South African psychiatry is extremely powerful and emotive (see especially Dommisse, 1987, and Lambley, 1980), and what may be termed a demonological characterisation of psychiatrists has appeared in the South African popular press (e.g. De Villiers, 1985)⁸. Calling for a more disciplined approach to the topic, Sashidharan and Platt (1987) argue:

Simply labelling a complex social system is no substitute for analysis; a closer examination of the way power is appropriated by a few in society at large and also within medicine ...[can expose] the common cause which the politicians and professionals share....Reification of psychiatry as essentially independent of political systems and the supposition that in South

Chapter 3: Apartheid and mental health

Africa the relationship between political ideology and professional practice is somehow aberrant or unnatural introduces an element of moral outrage rather than a clearer understanding of how one system feeds on the other and how they both reinforce each other. Without considering racism or capitalism as central themes in apartheid and how psychiatry/medicine through its selective professional concerns enables the expression and achievement of such an ideology it would be impossible to understand the political purpose and significance of what are conventionally seen as merely professional issues. (Sashidharan & Platt, 1987, p. 759).

Much of this dissertation is explicitly concerned with the politics of everyday psychiatric practice - particularly insofar as it relates to the question of 'culture' (as defined implicitly by the preponderance of authors discussed in the previous chapter).

Sashidharan and Platt go on to point out that any analysis of the political function of South African psychiatry must make mention of the major professional psychiatric association and give due regard to progressive movements in the health and mental health fields. I consider this question briefly in the following subsection.

B. Professional and alternative organisations

The Society of Psychiatrists of South Africa (SPSA) is a branch of the Medical Association of South Africa (MASA) mentioned earlier. Gillis's letters to *The Lancet* in 1977 and 1978 which can be described as apologist about South African psychiatry and psychiatrists were written on behalf of the SPSA. Unlike the Psychological Association of South Africa (PASA), the office-bearers of which are generally predominantly Afrikaans-speaking and from Afrikaans-medium institutions⁹, the SPSA often has English speakers from 'liberal' universities (like Gillis) as office-bearers. In 1985 the SPSA released the following statement:

The Society of Psychiatrists of South Africa (MASA) declares that:

1. The Society of Psychiatrists recognizes and deplores potentially harmful psychological effects on the people of South Africa as a result of any form of discrimination based on race, colour, gender or creed. The Society does and will strive for the elimination of all forms of discrimination that adversely affect mental health.

Chapter 3: Apartheid and mental health

2. The Society declares its opposition to any disparities in the quality of psychiatric services for all.
3. The Society declares its commitment to insist its members practise their profession as laid out in internationally accepted ethical codes in the declarations of Helsinki, Hawaii and Tokyo, and its determination to resist any form of abuse of psychiatric knowledge and skills for political ends or for any other purpose contrary to the best interests of the patients and their personal welfare.
4. The Society has by its representation and actions been responsible for many improvements in the services for all psychiatric patients in South Africa. The Society steadfastly declares its intention to continue these efforts.

An interesting feature of this statement is that it does not question the fundamental apartheid principle of racial segregation of facilities. A further feature is that the SPSA is portrayed as active in the fight against discrimination and in the improvement of facilities, but no details are given. Many would dispute both claims and the first in particular (Fluxman, 1985; Sashidharan & Platt, 1987). More fundamental than any of these aspects, however, is the fact that the statement seems based on the view that it is possible to separate the mental health sphere from the rest of the social, cultural, and political environment. In opposing 'all forms of discrimination that adversely affect mental health' (point 1 of the statement - it should be noted that a non-defining clause is used), the SPSA may be seen to be espousing either or both of the following positions:

1. The SPSA does not oppose forms of discrimination which do not adversely affect mental health.
2. The SPSA considers it its province to comment on the issue of mental health alone, and not on other social and political issues.

Both these positions demonstrate the extent to which the SPSA seems at the time to have viewed professional developments in psychiatry and the mental health field as relatively separate from other forms of social and cultural practice. This lack of reflexivity about the social and cultural construction of professional practice has an important parallel in the South African transcultural literature which overwhelmingly designates 'culture' as

inherently belonging to others - notably, Blacks. The SPSA can also be seen to be operating within the type of split between politics and professionalism noted by Sashidharan and Platt (1987), and quoted earlier.

Later statements by office-bearers of the Society (e.g. Ben-Arie & Nash, 1986) point to dissatisfaction with unequal facilities and care. Doubtless, the extent to which the Society has fought for equality of services would be questioned by many.

A very recent meeting of the SPSA and the academic heads of psychiatry departments in South Africa, I am informed (Allwood, personal communication), may herald a major change of direction for the SPSA. The SPSA is in the process of drafting a statement which clearly and unequivocally condemns the wastefulness of 'ethnic' departments of health, and the inequalities inherent in segregation. The SPSA, I understand, is in the process of committing itself to the abolition of racial segregation in psychiatric facilities throughout the country. At the time of writing, unfortunately, no statement is as yet available for public scrutiny, and it remains to be seen how actual practice will change in the wake of the forthcoming statement.

Some psychiatrists, dissatisfied with both the SPSA and with MASA in general, have found an ideological home in organisations such as NAMDA (defined above), and the Organisation for Appropriate Social Services in South Africa (OASSSA). OASSSA was formed in 1983 by a group of psychologists protesting the holding of a family therapy conference at Sun City. This venue is a casino resort situated in the homeland of Bophuthatswana. The psychologists concerned pointed out that there was an irony in holding a family therapy conference in a homeland - areas which have all been wracked by family disruption engendered by South African influx control legislation which requires that breadwinners finding employment in 'white South Africa' leave their families in the homelands¹⁰. In vast numbers of cases these breadwinners are able to visit their families annually at most. OASSSA is committed to democratic accountability in mental health and

social service care and to working towards post-apartheid mental health and welfare services.

NAMDA and OASSSA cooperate with other health and progressive organisations and trade unions on political campaigns around health issues and also on actual alternative service provision, notably in the fields of rehabilitation after detention or other acute forms of abuse. The vast majority of mental health professionals and psychiatrists in particular do not belong to such organisations. Most mental health professionals, then, have not taken up an overt political stand of the type implied by joining a progressive organisation. This does not mean, however, as will be seen in Part 3 of the dissertation, that ideological factors do not impinge on the consciousness of practitioners. There can scarcely be a mental health professional in the country oblivious to the power of the rhetoric directed against South African psychiatric and medical practice.

VI. Concluding comments

Any attempt to explore issues of culture in South African psychiatry without an examination of the complex relationships between apartheid and mental health must fail. Apartheid has been part of the cultural fabric of life for all South Africans for over forty years, and the history of discrimination in the country is far longer. If transcultural psychiatry is fundamentally about examining behaviour and practices in context, then the discipline must explore context in its broadest sense - and not only in the narrow, essentialist 'cultural' way suggested by much of the local transcultural psychiatric literature.

This argument applies equally though perhaps less obviously to the study of culture and psychiatry anywhere in the world (Kleinman, 1986; Littlewood & Lipsedge, 1986). I have argued elsewhere that the very clear issues in South African transcultural psychiatry may illuminate factors in the discipline as a whole (Swartz, 1985b). Apparently purely academic questions become quite clearly ideological issues when examined within the South African

context. An aspect of how this happens will be demonstrated in the following chapter's consideration of cultural relativism as realised in South African psychiatry.

The question of what enables practitioners to reproduce apartheid through their work is, as I have mentioned earlier, crucial. It is crucial not only to an understanding of what is happening currently, but also to assisting in the transformation of care into a more equitable system. Demonological attributions of blame and what Sashidharan and Platt (1987, p. 759) call 'moral outrage' can lead to little more than caricature. It is hoped that the material presented in Parts 2 and 3 will begin to give a more complex picture of practice in a supposedly liberal institution - a picture which has bearing not only on the psychiatry of cultures, but also on the cultures of psychiatry.

Notes to Chapter 3

1. At the time of writing, the Population Registration Act, which defines each South African by race, is still firmly on the statute books. This system of definition alone, regardless of any other changes, actual or promised, in state policy, ensures that the experience of every South African is strongly influenced by the racial label attached to him/her.
2. The Group Areas Act of 1950 as amended seeks to ensure that Black people will not live in white areas, where white hospitals are situated. *De facto*, a large and increasing number of Black people do live in such areas, and, in any event, domestic workers and others who live at their place of employment for most of their adult lives have always lived in white Group Areas with no threat of prosecution.
3. I received this information about the Department of Health response through a personal communication. As far as I am aware, the response was not made public.
4. This issue is taken up more fully in discussion of a case example in the following chapter.
5. It is to an extent comforting to note that in the same year as Potgieter's thesis was submitted - 1986 - Shaw (1986) completed a study of alienation focussing on coloured and white males. Shaw (1986) is clearly sensitive to political issues in the area, and alerts the reader to these.
6. I am not of course claiming here that all South African psychiatrists and mental health practitioners have been inactive in struggles against racism and exploitation, as will be seen later in the chapter. Psychiatrists, like other health professionals have, furthermore, from time to time made public statements about the negative effects of apartheid, discrimination and state repression (Benatar, 1989; Board of the Faculty of Medicine, University of Cape Town, 1986; Department of Psychiatry, University of Cape Town, 1986; Hart, 1988; Manganyi, 1987; van Niekerk et al, 1987).
7. Similar differences in tactics can of course be seen to be played out in international debates about policy towards South African in general, for example, in the tension between the (now officially defunct) 'constructive engagement' policy and the sanctions lobby in the USA, and the split between Britain and the rest of the Commonwealth on the issue of sanctions against South Africa.
8. Detailed analysis of texts both popular and academic on the evils of South African psychiatry cannot be undertaken here but should provide a fertile area for further study. It is interesting to note, for example, some structural similarities between Lambley's (1978) book and Dommissé's (1987) article. Both authors portray themselves as refugees from apartheid, and as victims of its machinations. The author note by Dommissé (1987, p. 749), in which he identifies himself and his relationship with the struggle against apartheid, incidentally, is very unusual in the context of the journal in which it appears - *Social Science and Medicine* usually does not carry such detailed identifying data about authors. Both authors, furthermore, couch much of their arguments in a victimological discourse - a form of writing and talk which has the paradoxical potential to disempower 'victims' even further (Levett, 1989; Swartz & Levett, 1989; Swartz et al, in press).
9. For a history of schisms on apartheid issues in psychological organisations in South Africa, see Louw (1986).
10. Influx control, as I have mentioned above, ceased to be official policy 1986, though alternative legislation ensures that a high degree of control is maintained.

Chapter 4

The question of relativism in South African psychiatry

Table of contents

I.	Introduction	81
II.	Complementarism and relativism in ethnopsychiatric theory	82
A.	Devereux's complementarism	82
B.	Cultural relativism	84
III.	The language of 'relativism' in South Africa	
	- a strategy for domination	87
IV.	Redefining culture in South Africa: the problem	89
V.	The production of psychiatric knowledge in South Africa	93
A.	Producing 'otherness' in a universalist context	95
1.	Finding otherness amidst diagnostic similarity	96
2.	Ascribing 'compliance problems' to otherness	97
VI.	Clinical practice and the search for	
	appropriate models of explanation	100
VII.	Implications and conclusions	106
	Notes	108

Chapter 4

The question of relativism in South African psychiatry

I. Introduction

The review of the South African transcultural psychiatry literature in Chapter 2 has demonstrated the centrality of the concept of 'culture' to that literature. In general, 'culture' has been shown to be understood in essentialist terms and in a fashion which does little to question the legitimacy function of the term in the defence and reproduction of state policy. Chapter 3 has shown some of the devastating effects of state policy on mental health care, amongst many other areas. Given that the concept of cultural relativism and respect for cultural diversity is so central both to South African transcultural psychiatry theory and apartheid ideology, the question arises as to the relationship between the concept of cultural relativism as used in South Africa and its status in cross-cultural psychiatry internationally. It will be recalled from the introductory chapter that a key feature of Kleinman's (1977) 'new cross-cultural psychiatry' is its emphasis on respect for differences between people of different backgrounds. Given that this same emphasis pervades legitimacy writing about apartheid and South African transcultural psychiatry, an important theoretical question arises. Is the South African oppressive use of the concept of cultural relativism simply aberrant in the international context, or is there something about the concept of cultural relativism itself which can be seen to provide fertile ground for legitimisation of oppressive practices¹? An answer to this complex question could help situate South African psychiatry within the broader sphere of international practices, and facilitate exploration of the interface between the South African psychiatrist as South African and as psychiatrist.

Debates concerning the merits or otherwise of cultural relativism run deep within international anthropology, and I cannot hope to do justice to them here (Bromley, 1987; Geertz, 1984; Nissim-Sabat, 1987; Washburn, 1987). My discussion in this chapter is, of

necessity, restricted and I shall not, for example, make any attempt to enter debate concerning the precise relationship between cultural relativism and the structural-functionalist tradition. I introduce my argument therefore by a brief consideration of the concepts of complementarism and relativism as used in international psychiatric theory, and not in the social sciences as a whole. I go on to show that far from allowing for the multiplicity of visions implied by these positions, the South African state's relativist discourse is in fact very constraining and coercive. Some key responses to this on the part of South African anthropologists opposed to state strategy are presented, and form part of a context for the discussion of the production of psychiatric knowledge in South Africa that follows. Some case examples illustrate the realisation of these same issues in clinical practice. The concluding section of this chapter emphasises the need to explore ideologies hidden within apparently rational, dispassionate approaches to the theory and practice of psychiatry, and paves the way for the empirical investigations to be reported on in Parts 2 and 3.

II. Complementarism and relativism in ethnopsychiatric theory

A. Devereux's complementarism

Devereux's *Ethnopschoanalysis* (1978) has as its basic argument the thesis that complementarism is a necessary basis for the understanding of human behaviour. According to Devereux, complementarism is not a theory but a 'methodological generalization' (p. 18) which states, essentially, that a multitude of theoretical perspectives on the same human activity will yield a more complete understanding than will a single perspective. The best-known intellectual precursor of Devereux's complementarism principle is Bohr's concept of complementarity. This concept attempts to deal with a central problem of quantum physics: that phenomena respond to measurement. Bohr was certainly not the first person to grapple with the relationship between observer and observed, but others had different ways of dealing with the problem. For example, in his *The logic of modern physics* (1932), Bridgman attempted to some extent to excise the

problem of the observer-observed relationship from science by advancing his system of operationism. According to this method, objects and concepts are defined empirically by the operations it takes to measure them. This procedure of operational definition yields a recipe for defining concepts from one perspective only. Furthermore, the operations involved in any single definition are generally speaking replicable by any number of observers. Operationism yields a series of empirical concepts which are ostensibly atheoretical and exist apart from any individual's assumptions: these concepts exist only in the recordable infinitely replicable procedures which define and contain them.

Bohr, by contrast, confronted the observer-observed relationship by accepting that a phenomenon that is being observed is different from the 'same' phenomenon when it is not being observed. Hence, different perspectives will yield different approximations to the thing 'out there' which is ultimately not fully knowable, precisely because it is being studied. A single method of observation becomes impossible.

In Anglo-American psychiatry the operationist paradigm has enjoyed considerable power, the strongest product of which is possibly the DSMIII (APA, 1980) and its revision in the DSM III-R (APA, 1987). Devereux's support of complementarity can be seen as a fundamental response to a dominant ideology, an attempt to restore the observer to a central place in the study of human behaviour. Furthermore, Devereux's insistence on the validity of both psychological and sociological modes of explanation (or of both psychoanalysis and anthropology) seriously challenges the idea of a single truth in any science.

Devereux does not go so far, however, as to suggest that any theory or perspective has value. Complementarism requires that the methods or theories used are 'valid' (1978, p. 18). Much of his work is concerned with searching for theories which have more utility than others. In his discussions of the phenomena he studies, furthermore, Devereux does not shrink from placing a value on what he sees. Hence he is prepared to commit himself

to a notion of 'normality' which is not contained simply by the particular context in which it appears, but is defined as well by structural criteria which are relatively context-independent (1980, pp. 3-71). Devereux's concern then is the realization or surface manifestation of structures in particular contexts.

B. Cultural relativism

In a chapter in a book devoted to cultural factors in mental health and therapy, Shweder and Bourne (1982) contrast relativism with universalism and evolutionism as paradigms of understanding. They define these terms in the following way.

Universalists are committed to the view that intellectual diversity is more apparent than real, that exotic idea systems, alien at first blush, are really more like our own than they initially appear.

Evolutionists are committed to the view that alien idea systems not only are truly different from our own, but are different in a special way; viz., other people's systems of ideas are really incipient and less adequate stages in the development of our own understandings.

Relativists, in contrast, are committed to the view that alien idea systems, while fundamentally different from our own, display an internal coherency which, on the one hand, can be understood but, on the other hand, cannot be judged.
(Shweder & Bourne, 1982, p. 98).

They argue that universalism is an approach which will '(a) emphasize likenesses and overlook specific differences... and/or (b) examine only a subset of the evidence' (p. 98). This by now fairly standard attack on universalism (cf. Fabrega, 1989b; Kleinman, 1977) argues that an essentially trivial grid will be placed on data, and no adequate context for the data will be provided. In the field of transcultural psychiatry the perspective provides a somewhat superficial catalogue of disorder which does not adequately address issues of sociogenesis (see e.g. Leff, 1981).

Evolutionism, as Shweder and Bourne refer to it, is a view which attributes to some groups deficits in cognitive skills, intellectual motivation, pertinent information and linguistic tools (p. 107). It is beyond the scope of this chapter to enter into discussion of Shweder and Bourne's treatment of the authors whom they describe as evolutionist, but the important

point for this chapter is that they make a strong case to demonstrate that the concept of deficit tends not to be useful in cultural anthropology. Littlewood and Lipsedge (1989) have shown that evolutionism of the type to which Shweder and Bourne refer - i.e. a crude progressivism, or what Shweder (1984) elsewhere terms 'developmentalism' - has a long and ignominious history in Western psychiatry. There is a particular affinity between evolutionism and psychiatry in that they both deal with human deficits, whether cognitive, emotional, or 'cultural', and evolutionism has been attractive even to psychiatrists of considerable sophistication. In linking the mental lives of 'savages' with those of 'neurotics' in the context of a theory which uses regression as a central concept, for example, Freud (1950), regardless of whatever else he was doing, was adding indirectly to the discourse of evolutionism.

The key feature which distinguishes relativism from either evolutionism or universalism is the way that it uses context. Nothing is explicable without context, and different contexts (including linguistic ones) nurture phenomena which cease to be directly comparable. Things are not essentially the same (universalism) or at different stages of development (evolutionism); they are radically and essentially different. The relativist view of the world is fundamentally more fragmented than either of the others but, it is argued, more accurate.

Different though relativism may be from universalism and evolutionism, however, relativism and universalism are equally attractive to liberal ideology, though at different levels. As Gellner (1985) puts it:

Liberalism, tolerance, pluralism, incline many to find pleasure in the idea of a multiplicity of men and visions; but the equally reputable and enlightened desire for objectivity and universality leads to a desire that at least the world and truth be but one, and not many. (The tolerant endorsement of human diversity becomes very tangled if one realises that very many past and alien visions have themselves in turn been internally exclusive, intolerant and ethnocentric; so that if we, in our tolerant way, endorse them, we thereby also endorse or encourage intolerance at second hand. This might be called the dilemma of the liberal intellectual.)

(Gellner, 1985, pp. 83-4).

Western psychiatry, being essentially a liberal enterprise (see Ingleby, 1981), finds itself precisely in the dilemma to which Gellner refers. Part of the difficulty with psychiatric relativism is that the actual practice of psychiatry cannot be radically relativistic. Unlike the author of a descriptive (as opposed to prescriptive) grammar, for example, the mental health practitioner cannot simply observe and celebrate diversity; it is the job of the practitioner to intervene. It is partly (though not entirely) because of this reality that Devereux (1980) refuses to abandon some universalist tenets. He recognizes the need for many perspectives (hence, his reliance on complementarism) but refuses to abandon his conception of normality. Hence, his statement that 'from a psychiatric point of view the valid criteria for normality are absolute' (1980, p. 5) is not a contradiction of complementarism but simply a statement of what Devereux sees as a fundamental aspect of psychiatry. In the end, psychiatry depends on a criterion of normality which can be adapted by context but which preexists examination of any particular culture. Regardless of whether the distinction between normal and abnormal is seen as categorical or very unclear indeed, and regardless of where the 'blame' for abnormality is located, psychiatry as a practice always works on the principle that there are more or less desirable ways of living. Even if it is argued that different practitioners may have different criteria for what is desirable, and that these criteria are themselves culturally determined, it is a universal necessity for practice to have criteria.

In concluding his essay which is designed, as he puts it, to destroy a fear (Geertz, 1984, p. 263) about cultural relativism, Geertz writes:

The objection to an anti-relativism approach is not that it rejects an it's-all-how-you-look-at-it approach to knowledge or a when-in-Rome approach to morality, but that it imagines that they can only be defeated by placing morality beyond culture and knowledge beyond both. This, speaking of things which must needs be so, is no longer possible. If we wanted home truths, we should have stayed at home.
(Geertz, 1984, p. 276).

This quotation raises certain questions about the relationship between professional ethnopsychiatric practice and relativism. In discussing the different points of view in the field, Kleinman (1988, p. 33) contrasts 'the extreme relativism of some antipsychiatry anthropologists' with 'the universalistic fundamentalism of some card-carrying biological psychiatrists', calling both positions 'outrageously ideological'. Clearly, the 'card-carrying biological psychiatrists', wherever they may go, 'stay at home' with the 'home truths' of biological psychiatry, and the 'antipsychiatry anthropologists' are indeed in some danger of a 'when-in-Rome' approach. Questions about relativism as a theoretical perspective inevitably become translated into questions about the nature of psychiatric practice which is one form of social practice.

It is of course arguable that the distinction between theory and practice is often a false one and that any social or scientific practice is informed by theories implicit or explicit. Though this may be so, it is important for the current discussion to note that theories as they are used in practice are often modified and subtly changed, whether consciously or unconsciously. A distinction needs to be made between theory as it is conceived and theory-in-use (theory as an item of cultural currency). A central question that needs to be raised in this regard is this: when theorists attempt to behave in a relativist way, do they behave in such a manner consistently? Is the tolerance associated with relativism likely to be applied equally to Afrikaners as it is to Blacks, for example, or is tolerance, ironically, reserved for those who might in evolutionist discourse be termed 'primitives'? These are clearly not questions about relativism in itself, but questions of this type become crucial in any analysis attempting to examine South African psychiatric knowledge and practice².

III. The language of 'relativism' in South Africa - a strategy for domination

A current major ideological task of the South African state is to create a vision of reality which will allow maintenance or entrenchment of power imbalances while at the same time giving the appearance of liberalization. It is necessary to cast domination and oppression

into other, more acceptable terms. Resistance also needs to be recast in order that it can be seen as an inappropriate response to state policy. In discussing the rhetoric of the South African state particularly since 1978, Posel (1984) argues that

The new 'reformist' language currently prominent within the South African state upholds ...a standard of technocratic rationality, recognisable in two guises: in the call for 'realistic' and 'pragmatic' government, and in the powers assigned to 'experts' in administering 'objective' solutions to 'national problems'.
(Posel, 1984, p. 2).

The language of cultural relativism as used by the South African state depends on calls for recognition of cultural diversity not simply on moral grounds, but on 'practical' grounds as well. Hence it becomes the duty of the South African state to protect separate group identities (so that the 'cultures' will not be swamped by others), but even more fundamentally it is also incumbent upon the state to recognize the 'facts' of these identities purely in pragmatic terms. Posel points out that the state has increasingly presented cultural diversity as a 'fact' which no pragmatist can afford to ignore. Cultural diversity/multinationalism/ethnicity is presented as value-free, preexisting any policy. The state becomes bound by rules of common sense to respond to the facts, and its apartheid policy (or whatever its new guise is) is seen as the only hard-headed, logical response to these facts. A climate is thus created in which to deny the state's version of cultural relativism is to deny 'reality'. Opponents of South African policy can then be cast as people who are out of touch with reality, or sentimental dreamers.

Posel's identification of the technicist cast to South African 'reformist' language is particularly relevant to the present discussion. Psychiatry is a field dominated by 'experts' of the type required by state strategy to provide 'objective' solutions. The entire mental health enterprise, expertise in which field is designated 'scientific', becomes an arena in which the dominance of the state ideology can be reproduced and 'confirmed scientifically'. It may even be argued, as is implied in Littlewood and Lipsedge's (1989) work, that psychiatry in particular is an area where ideological reproduction is crucial. This is because

of the association between 'primitives' and 'madness' as well as the social regulatory function of mental health practice.

Scientific though psychiatry, clinical psychology and similar 'helping professions' may be, they are however applied disciplines. They have to rely for their 'givens' on 'common sense' (i.e. ideologically influenced cultural knowledge) or more basic social sciences. Social anthropologists opposed to state policies have considered at some length issues concerning the nature of 'categories' of culture in South Africa. Some issues concerning their response will now be considered.

IV. Redefining culture in South Africa: the problem

A recent South African textbook aimed chiefly at undergraduate students and what the back cover terms 'interested general readers' states in its introduction that

different races and ethnic groups, unique cultures and traditions, do not exist in any ultimate sense in South Africa, and are real only to the extent that they are the product of a particular world-view.

(Sharp, 1988, p. 1).

The author of this introduction goes on to describe this view as 'a heresy' (Sharp, 1988, p. 1), and much of the book amounts to a defence of this 'heretical' position. The authors set themselves the task of laying bare what they term the 'changing discourse of domination' (Sharp, 1988, p. 6) in South Africa, and show how terms such as 'race', 'culture', 'tribe', 'tradition', and 'community' have been used at different times to legitimate the interests of those who hold power in South Africa (cf. Posel, 1984).

'Heresy' is a strong word to describe what may be termed a social constructionist³ approach to the understanding of the production of ideas about groups. Its theological connotations are particularly apposite in the context of the history of the use of religion and the Dutch Reformed Church in particular as a basis for legitimization of apartheid ideology. The

strength of the word 'heresy' accurately reflects the intensity of feeling about the construction of groups that is the cornerstone of apartheid policy. At the time of writing this chapter, for example, it is still mandatory for each South African to be classified along 'racial' lines. Regardless of whether this classification seems relevant to persons thus classified, it determines where they may live, go to school, and whether they may vote in the House of Assembly, the whites-only house of parliament in which *de facto* the country's executive power is vested. It is not possible in South Africa to claim that groups of people are different from each other without at some level recalling, consciously or unconsciously, a major basis for justification of oppressive practices. In the same introductory textbook, Thornton (1988) writes that ideas about the existence of separate cultures

have been used to justify repressive and brutal forms of government by arguing that, like an organism, a culture or nation must defend itself against internal, as well as external, enemies. If the initial premise that cultures are 'owned' by nations is accepted, the activities of repressive state bureaucracies may be justified as a form of political hygiene. (Thornton, 1988, p. 19).

In a lucid exposition which recalls many of the issues of debate in contemporary culture theory (Shweder and Le Vine, 1984), Thornton (1988) demonstrates the fact that many of the 'boundaries' around cultures in South Africa (and elsewhere) have in fact been imposed on people within specific historical contexts. Thornton argues instead that modern anthropology should regard culture as a resource which can be used in social relations rather than as a static entity which defines people from the outside, and should in addition recognise the fact that culture changes. In a later paper, Thornton (1989) states his position clearly:

I advocate, then, a particular view of culture: Culture is a set of resources which consists of objects, sounds and languages (one or many), traditions, customs, habits, beliefs and so on, but also includes secrecy, violence, deceit, revolution and innovation - all *essentially* and constantly self-undermining and mutually contradictory. Somehow, in trying to understand 'the ways of being human,' we have managed to forget that the ways of being *inhuman* are also part of culture. But most importantly, the *idea of culture* is itself part of culture - indeed *having an idea of culture*, that is, possessing the notion that culture is what makes us human, is perhaps the *sine qua non* of having culture at all. It is this reflexivity of culture - that the idea of culture is part of culture - that is really the important thing that current thought about culture has begun to teach us. (Thornton, 1989, p. 9).

In the same paper, Thornton (1989) invokes the notion of 'discourse'⁴ and 'discourses' to demonstrate the cultural construction of the notion of culture. In particular, he discusses the concept of the *authoritative discourse* by which 'language is taken not only as the privileged mode of representation but of coercion as well (Thornton, 1989, p. 26). An important implication of Thornton's work for the present discussion is that to define people from the outside as belonging to a specific 'cultural group' is to engage in a political act which has particular ramifications in South Africa.

These ramifications have been evident in various trends in the production of knowledge about 'culture' in South Africa. Sharp (1981) has traced the history of the discipline known as *volkekunde* ('cultural anthropology'). *Volkekunde* is taught and applied in Afrikaans medium universities, universities created by the South African government for members of other 'cultural groups' (i.e. people who are not white) and in various state organizations such as the Defence Force. Sharp argues that *volkekunde* assigns primacy to 'culture' as a mode of explaining South Africa's diversity, and many of its strengths and weaknesses, and is taken as the basis on which all knowledge is to be built. As Sharp shows, the *volkekunde* argument has repeatedly been used to provide 'scientific' support for apartheid or 'separate development' policies⁵. In this article and in a companion one (Sharp, 1980) he demonstrates that the *volkekunde* assumption of the primacy of 'culture' used as an analytical tool in this sense is in fact not unique to *volkekunde*. It extends into social anthropology as well - even into social anthropology produced by people critical of apartheid and similar policies.

In the face of an articulate attack on the production of ideas about cultural difference in the service of the current system of domination, it is tempting to opt instead for an approach which deemphasizes difference and emphasizes similarity. Kottler (1988) argues that this is indeed the position taken by the contributors to the Boonzaier and Sharp (1988) text mentioned above. For example, Thornton (1988) states:

Chapter 4: Relativism in South African psychiatry

In the marketplace and workplace, listening to music or watching television, at homes and in churches, people in fact experience the same desires, profess the same religions, follow the same leaders, and eat the same cornflakes, notwithstanding their 'multicultural' condition! (Thornton, 1988, p. 18).

Thornton makes four assertions here about what people 'in fact' do:

1. They experience the same desires
2. They profess the same religions
3. They follow the same leaders
4. They eat the same cornflakes

An important feature of these statements for the purposes of this dissertation is that all of them are easily translated into empirically testable questions (e.g. Do people coming from what some would call 'different cultures' eat the same cornflakes?), except for the first. How does one know that people 'experience the same desires'? In terms of the way that knowledge is divided in contemporary academic life, this becomes a difficult psychological, psychiatric, or (perhaps most appropriately) psychoanalytic question, not open to easy empirical investigation. It is precisely the psychological dimension which according to Kottler (1988) is ignored by the 'similarities' position in South Africa. Yet this is a key dimension for psychiatry.

Kottler (1988) points out further that adhering to the 'similarities' position is not the only way theorists can express dissatisfaction with state strategies⁶. Proponents of what she terms the 'differences' position are not automatically in favour of government policy:

It is irrelevant if the Government is telling Zulu people that they are bounded by their own special culture which is peculiar to them. They know who they are essentially, so that at one level [they] can indeed be Zulu, yet at a deeper level are Africans with a world-view or orientation common to Africans in general; while in a more external sense they are also South Africans.

(Ngubane, 1988, pp. 11-12, as quoted by Kottler, 1988, p. 8).

Ngubane seems to be suggesting here that she subscribes to a heresy which she views as more fundamental than that proposed by the contributors to the Boonzaier and Sharp (1988) volume. Instead of replacing emphasis on socially constructed differences with emphasis on similarities, Ngubane commits the heresy of saying that differences are indeed important, but not in the way the state uses them. This view, Ngubane would argue, is not one imposed from the outside, but part of the cultural heritage of different South African groups (cf Ngubane, 1977), and essential to the understanding of the psychology of black South Africans.

V. The production of psychiatric knowledge in South Africa⁷

Psychiatric knowledge in South Africa can be seen to be caught between a variety of positions which may influence it: the pseudo-relativism of state policy, the 'similarities' counter-attack, and the 'differences' counter-counter-position⁸. I have demonstrated in previous chapters the central position that state policy has in providing a context for this knowledge. Given the nature of South African society, as we have seen, it is tempting to argue over-simplistically that psychiatric knowledge produced in this country is part of a broad conspiracy against blacks (cf Lambley, 1980). Psychiatric knowledge in South Africa, on the contrary, as in other countries, has a primarily pragmatic motivation (Swartz & Foster, 1984). The aim of much South African research is to create knowledge which will contribute to the understanding and treatment of mental illness in black people.

Though conspiracy theories have a popular history in psychiatry (Laing & Esterson, 1964; Szasz, 1971; see Littlewood & Lipsedge, 1989, for a critique) they are often based on the belief that evil intent is at the basis of work which either is in itself racist or oppressive in orientation or comes to be used for oppressive purposes. This belief is reductive in that it locates ideology in individual motives and fails to take account of the extent to which ideology determines what is 'sayable', what cannot be said or seen, and what becomes

common sense, and it is precisely with this type of question that much of my work is concerned.

In trying to establish a framework for discussion in the rest of this chapter, I shall draw on Said's (1978) discussion of Orientalism. In his introduction to his argument, Said identifies a number of meanings for the term. According to Said, the most obvious definition of Orientalism is as an academic field. It can also be defined as 'a style of thought based upon an ontological and epistemological distinction made between "the Orient" and (most of the time) "the Occident" ' (p. 2). Most importantly for Said's purposes, however, and for this discussion, Orientalism can be seen as a discourse in the Foucaultian sense:

My contention is that without examining Orientalism as a discourse one cannot possibly understand the enormously systematic discipline by which European culture was able to manage - and even produce - the Orient politically, sociologically, militarily, ideologically, scientifically and imaginatively during the post-enlightenment period.... Because of Orientalism the Orient was not (and is not) a free subject of thought or action. This is not to say that Orientalism unilaterally determines what can be said about the Orient, but that it is the whole network of interests inevitably brought to bear on (and therefore always involved in) any occasion when that peculiar entity 'the Orient' is in question. (Said, 1978, p. 3).

South African psychiatry, like Orientalism, can be seen as an academic discipline, but also as part of a cultural discourse which creates its object. Psychiatry creates its object of study and constellates it as part of a particular kind of discourse. The fundamental notion of this discourse is that of 'otherness'. I use this term in contradistinction to that of 'difference', in that I take 'difference' to be relatively more value-neutral and 'otherness' more closely associated with the forms of cultural reproduction I discuss below. The notion of 'otherness' is one which serves to perpetuate divisions and also to define the not-other. By defining the 'other' or the bizarre, South Africans writing in the field of psychiatry are simultaneously defining both themselves and their own 'culture'.

Writing in the *South African Journal of Ethnology*, a journal with a strong *volkekunde* flavour, De Villiers (1985) makes the following series of statements:

In Xhosa tradition illness is regarded as a type of misfortune..., consequently ideas about causes of illness are closely associated with ideas about causes of misfortune in general. (p.48).

Available information allows for a distinction between supernatural and natural causation. This distinction is made in relation to cultural considerations of the target population and it is not verbally expressed, possibly only existing in a subconscious awareness among the people who identify a particular cause, but not the type of causation. (p.52).

While supernatural and natural causes are mutually exclusive, factors such as deterioration in a patient's condition may lead to reinterpretation of the cause, so that a natural cause is rejected for a supernatural one. (p.52).

These quotations place themselves, in a sense, as much by what they omit as what they say. They imply that supernatural causation is the province of Xhosas, that the link between illness and misfortune is unique to this group (or groups of this type). It is by now well established that even physicians in the biomedical tradition do in fact have a range of ways of responding to illness, not all of them neatly fitting into a 'natural' pigeonhole (Hahn & Gaines, 1985). De Villiers does not address this issue, but by implication disallows an examination of similarities between her subjects and 'Westerners'⁹. The second of the three quotations from De Villiers also makes an implicit link between irrationality and 'Xhosa culture' by focusing on what she terms the 'subconscious'. One wonders how many other groups *consciously* choose explanatory models!

A. Producing 'otherness' in a universalist context

The discourse of 'otherness', far from being associated uniquely with relativist or pseudo-relativist work in South Africa, appears in other contexts as well. Much of conventional South African psychiatry - particularly that produced by proponents of ostensibly universalist (largely British) biomedical theory and practice - is intent on finding similarities between groups, but remains locked within the discourse of 'otherness'. A major focus of studies of this type is on similarities between psychiatric syndromes amongst various groups, with the implicit aim being to explore the universal applicability of 'Western' psychiatry. I shall use two examples to illustrate the problems with this position.

1. Finding otherness amidst diagnostic similarity

Using the Present State Examination (Wing et al, 1974), Teggin et al (1985) investigated the symptoms of schizophrenia in white, coloured and Black psychiatric in-patients. Their study revealed great similarities in prevalence of syndromes. They conclude that 'this study provides qualified evidence for similarity in the psychiatric manifestations of schizophrenic patients from diverse cultural and social groups' (p. 85).

How does this universalist conclusion (in the sense attacked by Kleinman, 1977 as the 'old transcultural psychiatry') contribute to the discourse of otherness? One way in which this occurs is the manner in which the authors deal with the one 'true difference' observed between Blacks on the one hand and whites and coloureds on the other. Blacks were found to have significantly more olfactory hallucinations than were the other groups, and the finding is discussed as follows:

Significantly more black patients were rated on the syndrome of olfactory hallucinations, which supports the findings... that these symptoms occur with relatively high frequency among Kenyan patients.
(Teggin et al, 1985, p. 868).

This statement lays bare some of the assumptions behind the approach. The authors do not explain how a finding in Cape Town, South Africa can 'support' a finding in Kenya, on a completely different population. No discussion is given as to why Kenyans and Black South Africans are comparable groups. Whether they are in fact comparable or not is beyond the scope of this chapter; reading the article in question, however, one cannot but reach the conclusion that what presumably unites Kenyans and Black South Africans is that both groups are black. In order to explain the differences observed, the authors are drawing on the 'otherness' of all blacks, regardless of how diverse the groups may be. If I am correct in my assumptions, then the authors of the article can be seen to be producing 'blackness' as a concept, in the same way that Said speaks of the production of the Orient through the discourse of Orientalism. This otherness or blackness (replete with racist

overtones, regardless of the intention of the authors) provides the background for any similarities seen.

The knowledge created by work of this kind (regardless of whether it comes from South Africa) is fundamentally decontextualized, and its concepts (such as 'culture' and 'mental illness') reified. Material reality is nothing more than a modifying factor, and the implicit dimension along which people are measured is that of otherness - a dimension which clearly elaborates aspects of South African state ideology.

2. Ascribing 'compliance problems' to otherness

The ideological reproduction referred to above takes on a more serious cast when ascriptions are made concerning the effectiveness and accessibility of psychiatric treatment to Black patients. Gillis et al (1989) report on an attempt to improve compliance with psychotropic medication on the part of Black patients who have been discharged from a psychiatric institution. They cite previous research indicating that Black patients comply far worse with medication than do whites and coloureds, and argue that this contributes to a high readmission rate on the part of Blacks. They demonstrate that various methods of instructing Black patients about medication use while they are in hospital are far inferior in assuring compliance than is a post-discharge home visit on the part of a community psychiatric nurse in which the purpose of the medication is explained to both patient and a relative. This single visit improves compliance dramatically.

This is a clinically useful piece of information but the way in which it is discussed is striking in terms of the concerns of the current chapter. Most of the discussion of the results centres on the researchers' view that the reason for poor compliance in the Black patients lies within the African 'culture':

Kleinman speaks of an 'explanatory model' by which he means the way the patient actually understands medication. In our situation this is coloured by the traditional African view that the causation of mental illness lies in a disturbance in the whole being and takes account of

powers in the unseen world including the protection of ancestors, witchcraft and spirit forces. The psychiatrist's pills are not enough. The traditional healer, on the other hand, operates within the patient's own milieu, his remedies being non-medical in the form of rituals, social acts and animal sacrifices.
(Gillis et al, 1989, p. 207).

Gillis et al (1989) go on to claim that with increasing urbanisation, Blacks come to believe in Western psychiatry along with 'traditional explanations' (p. 270), and, 'with increasing acculturation' (p. 270), they eventually reject the traditional explanations in favour of Western ones.

The article clearly takes no account at all of the politics of 'compliance' (Trostle, 1988; Zola, 1981). It also demonstrates clearly how it is possible to transform the culturally relativist stance of Kleinman's 'explanatory models' into a sophisticated variation on pejorative labelling of patients and their irrationality. The 'explanatory model' concept should more properly be viewed as an invitation to enter the patient's perspective on medication (Hunt et al, 1989; Trostle et al, 1983), and to problematise the physician perspective (Hahn & Gaines, 1985; Stein, 1986). Gillis et al (1989) fail to treat the 'explanatory model' concept as a conceptual device used to understand the positions of *both* clinician *and* patient (Kleinman, 1978)¹⁰. More serious than this, Gillis et al (1989) confidently assume that the explanatory model of the Black patients they have studied must be that of the reified 'African culture', without having attempted to elicit the patients' views in any way. The emic 'explanatory model' concept has rapidly become a form of ethnocentric 'cultural diagnosis'. What is particularly interesting here is the extent to which Kleinman's argument has been read selectively. Kleinman states quite clearly:

When... [patient and practitioner] explanatory models are in conflict, the result may be patient noncompliance, and dissatisfaction, missed diagnosis, inappropriate treatment, and poor care. Such differences and conflicts often occur when there is no difference in the cultural backgrounds of patient and physician because of the basic discrepancies between the ethnomedical categories used by patients and the biomedical categories used by doctors. (The same conflicts may arise, albeit much less often, between the explanatory models of patients and of indigenous healers).
(Kleinman, 1978, p. 428).

Even if Kleinman (1978) can be accused of using a somewhat simplistic notion of 'culture' in this quotation, he is quite explicitly not dividing the world into the two neat halves suggested by Gillis et al (1989). It is hardly surprising that Gillis et al's (1989) presentation of their version of cultural relativism rapidly lapses into frank evolutionism.

The inconsistency with which the discourse of 'otherness' is used by Gillis et al (1989) is illuminating. They cite a number of South African authors in support of their view that Blacks comply better with traditional healers than with psychiatry. No South African author, including all those cited by Gillis et al, has formally compared compliance with biomedical as opposed to 'traditional African' treatments, much less found any difference. The difference is simply asserted (see especially Bürhmann, 1980; Cheetham & Griffiths, 1981). This notion of 'cultural difference' is useful in attributing Blacks' poor compliance to their 'culture' rather than to the possibility that facilities in general do not cater adequately to the needs of 'Blacks'. When, however, Gillis et al (1989) are able to demonstrate that a very simple intervention is able to improve compliance dramatically, the conclusion is that 'one home visit cut the Gordian knot of cultural complexity' (p. 208). The world of the Black patient may be 'other', mysterious, and primitive, but there is no question that if necessary psychiatry has the power to break through into this other world, and to reassert the dominance of the universal biomedical system.

In this universalist context, then, the relativist notion of the 'explanatory model' serves a dual function. It provides a partial abrogation of responsibility on the part of psychiatric services for differences in patient behaviour, and compliance specifically, by race. Secondly, though, it allows for reproduction of the image of greater rationality and power on the part of South African psychiatry as opposed to that of 'traditional African culture'. There is some inconsistency between the construction of these two functions - in the first 'African culture' creates a powerful and almost impenetrable wall through which the Westerner has great difficulty breaking, and in the second this wall crumbles in the face of

the power of western research. This is less important, however, than the fact that both functions reproduce existing power relations and implicit strategies of domination.

VI. Clinical practice and the search for appropriate models of explanation

It has been my consistent argument thus far that South Africans in the field of psychiatry find themselves located within a particular dominant discourse or at very least within the kinds of oppositional responses the discourse invites. By saying this I do not imply that South Africans are passive bearers of ideology. I do not accept either that the majority of mental health professionals are out to do anything other than what they perceive to be the best for their patients¹¹. Nowhere are the difficulties of being a South African mental health professional more clear than in the field of actual clinical practice, where the demand to do one's best in structurally less-than-ideal circumstances is strongest. I shall illustrate the problems by means of two case examples, both from my own clinical experience of some years ago.

Case 1 : Ms A

Ms A was a coloured woman of very dark complexion (i.e. she looks Black), in her mid-thirties at the time of referral. She was divorced with one son and she lived with her parents and son in a house in a small city some 800km from Cape Town. She was referred to a large psychiatric hospital in Cape Town after the only psychiatric services (all out-patient) in her city felt they could no longer cope with her. Her presenting problem was that she would often find herself lying on the sidewalk with her legs apart and her panties beside her. She never had any recollection of how she had got into this state and she thought that perhaps other people had taken her panties off her after knocking her out. Some indication of how she negotiated her sick role could be gleaned from the fact that she was taking 18 different psychotropic drugs a day, dispensed by various different practitioners. On admission she was taken off all medication, with no apparent change in her behaviour. I was responsible for the management of the case.

During the first history-taking session, Ms A, though apparently unaware of doing so, fondled my ankle with her bare foot. She spoke under pressure and it was very difficult to keep her talk on the topic at hand (though she was by no means thought-disordered). I got the impression that the more rigidly I tried to keep to the standard (British - model) history-taking format, the more irritated she became that I did not want to hear what she wanted to say. At the end of this unsuccessful interview, Ms A asked me if I would give her 20 cents because she wanted to use the public telephone. I declined, and she went off to the dining hall for the evening meal. I was told the following morning that she had stood on a table there, and claimed that she had just been raped. She had then lain on the floor.

After this event, Ms A settled well on the ward, and she was later discharged asymptomatic. Unfortunately, I am unaware of her follow-up details.

Discussion

How does one interpret Ms A's behaviour? Her arrival at the hospital caused considerable interest amongst the clinical staff. More junior members were encouraged to come to the ward and talk to Ms A as, it was said, classic Freudian hysteria is now very rare in the 'Western world' but is still seen in Africa in people who are not white¹². I do not wish to enter into any discussion here of whether this statement is empirically true or not, but I do want to point out the implicit evolutionism - Ms A and her ilk are curiosities, bearers of an illness of the past.

Clinically, this view of the patient seems to do little more than to distance the patient from the professionals. It provides a context in a sense in that it alludes to history, but in such a reified manner that it is not particularly useful. The discourse of otherness reinforces the divisions in South African society, and more firmly defines the clinicians as 'culturally different' from people of Ms A's social stratum.

There were, however, other, less reductive ways of looking at the case of Ms A. Her interaction with me, though clearly 'hysterical' in a classical sense, also occurred within a particular context. I am a white South African; she is coloured. A stereotypical relationship (though in reality by no means the most common) between white and coloured South Africans is that of begging. The coloured person begs, the white either agrees or disagrees to give money. In my role as a clinician I was attempting as far as possible to divorce myself from all preconceptions or cultural stereotypes that I might have, but this woman was reminding me that South African social factors do not stop at the hospital gates. She was forcing me to confront the ambiguity of my attempts at clinical neutrality. She was in a very real sense 'raped' by me - both by my insistence on a mode of clinical

procedure which did not adequately receive her view of herself, and by white maleness. This white maleness in South African society offers the promise (the reality) of power which cannot be hers. Her request for money can be seen both as a demand that she be paid for allowing me the pleasure of my exercise of power (as a prostitute or concubine might be paid), and as an attempt to receive part of that power for herself. Part of why she saw herself as raped, I suspect, was that she was not paid.

This discussion is not designed to imply either that Ms A was an innocent victim of my evil machinations, or that she had consciously created an illness in order to expose contradictions in South African psychiatry. What I am suggesting, however, is that the case of Ms A demonstrates that instead of focussing on 'otherness', we can with more profit begin to focus on the common cultural context encapsulating both clinician and patient. Goldstein's (1982) comment that 'it take two to make a diagnosis - a patient with a set of symptoms and a physician who gives them the label he deems appropriate' (p. 211) can be expanded to other aspects of the clinical encounter. Issues of power, class and colour existed for both me and Ms A - they were not hers alone, and my behaviour was determined to some extent by my own emotional reactions to them. Our encounter crystallized for me much about my own position as a white South African whose concern for his patients is inextricably confounded with his own social position. Ms A and I are equally part of a particular South African 'culture'.

A final question that needs to be addressed in the discussion of this case is that of 'Why hysteria?', given that the essentially evolutionist reduction of hysteria to a relic of the Western past is not satisfactory. I cannot begin to deal fully with this question here, but will sketch some of the parameters for what I see as a more adequate contextual understanding. I must reiterate that this woman is classified coloured. She speaks English and Afrikaans at home. She does not belong to those groups where, some would argue, spirit possession can be 'culturally' acceptable (see for example Ngubane, 1977). The 'cultural' explanation (in the sense used in South African state discourse), therefore, cannot

be applied. What becomes necessary in this case is an understanding of the matrix of familial and social relationships in which this woman finds herself. This includes some understanding of the woman's position within power relationships in South Africa. Foucault (1978) has suggested that the 'hysterization of women's bodies' (p. 104), as he calls it, has been, since the eighteenth century, a feature involved in the harnessing of sexuality within a structure of power¹³.

Sexuality must not be thought of as a kind of natural given which power tries to hold in check, or as an obscure domain which knowledge tries gradually to uncover. It is the name that can be given to a historical construct: not a furtive reality that is difficult to grasp, but a great surface network in which the stimulation of bodies, the intensification of pleasures, the incitement to discourse, the formation of special knowledges, the strengthening of controls and resistances, are linked to one another, in accordance with a few major strategies of knowledge and power.

(Foucault, 1978, pp. 105-106).

This woman's 'perverse pleasure'(p. 105) - her hysteria - can be understood not only as a psychological problem, but also as her contribution to an historically specific discourse. In his discussion of culture-bound syndromes in Malaya, Lee (1981) uses Turner's concepts of structure and anti-structure to argue that these syndromes are not pathological but: 'an integral part of Malay cultural reality' (p. 245). What I am arguing here with respect to Ms A's hysteria is not that it is either 'normal' or 'culturally acceptable' (this is clearly not the case), but that it does have a function similar to that alluded to by Lee. It helps to reproduce the South African discourse of otherness precisely by presenting a picture of madness which is, apparently, so antiquated. Hysteria is a form of madness of the Western past (whether this is empirically true, once again, is irrelevant here - I am talking at the level of ideological production) and women like Ms A re-emphasize the Romantic association between darkness of skin and the primitive. Ms A, through the theatrical language of her condition, was informing me and other clinicians of how we had captured our own sexuality within what Foucault would call an appropriate domain. She was confirming us in our positions while at the same time reinforcing the image of otherness as crystallized within herself.

I do not pretend to have a complete explanation of Ms A's behaviour. I do wish to suggest, however, that her symptoms and our reactions to them played some part in furthering our function (as clinicians) of reproducing South African power discourse. Our technicist response to her, such as the prescription of 18 kinds of psychotropic drugs, and attempts to take a formal history from a woman whose story was not 'formal', reproduced aspects of the language of legitimation in South Africa.

I do not think that clinically we served her badly at the hospital, and I also do not suggest that her being a South African mysteriously 'caused' her to be an hysteric. Her case does illustrate, however, the way in which symptoms and responses to them are elaborated within a particular ideological context and not simply in the context of many neatly separate 'cultures', all having different 'norms', 'values' and so on. The ideological context to which I refer is not one which can be escaped by anyone, least of all by those who seek to enter what has been termed the 'cosmology' or 'world view' of black people as discussed in Chapter 2. Mental health practice is inevitably involved in the reproduction of ideologies. Ms A's case serves as an illustration of how both patients and clinicians are involved in the process.

Case 2 : Mr B

Mr B was a Xhosa-speaking man in his late forties, a school principal in a rural area. Prior to admission he had been behaving increasingly bizarrely and had become verbally aggressive. His behaviour fitted the typical picture of frontal lobe syndrome, which was confirmed on examination and later treated.

It is not surprising in view of Mr B's condition that he was difficult to manage during his time on the ward prior to the completion of his diagnostic assessment. The particular ward to which Mr B was assigned had compulsory group meetings three times a week. He was extremely disruptive in these, complaining that nobody understood him. His command of English was excellent but his Afrikaans (the home language of most of the other patients on the ward, all of whom were classified coloured) was poor. Most patients used Afrikaans in group meetings, much to Mr B's annoyance. From the time of his second group meeting and until he was transferred to another ward, he spoke only Xhosa during group meetings, though he spoke English at other times. Nobody else on the ward (staff or patients) could understand Xhosa.

Discussion

Mr B's behaviour was clearly neither 'culturally determined' nor 'culturally acceptable'. However, the manner in which he expressed his dissatisfaction with the hospital exposed contradictions within the system. Like other such institutions in South Africa, the hospital was racially segregated. The form of segregation, however, did not follow the 'cultural' lines as put forward in official government policy. Whites were placed in one section of the hospital, and all other patients in another. As it happens all the patients on Mr B's particular ward were, except for Mr B himself, coloured. All the staff were white or coloured. No special arrangements were made for Mr B's 'cultural needs'. His choice to speak Xhosa in group meetings which were ostensibly designed to facilitate patients' hospital adjustment demonstrated clearly how the system was capable of making very little true provision for his needs. It is not at all uncommon in multilingual societies for clinical staff to be ignorant of their patients' home language (see, e.g. Marcos et al, 1973), and clearly this is not an ideal situation anywhere. But the South African state claims that its policies are designed to give privileged place to what it terms 'cultural' matters, and furthermore by legislation it defines Black language groups as cultural groups. Mr B, whatever else he was expressing with his clearly disturbed behaviour, was making an accurate attack on the dishonesty of the system which defined him in one way but made no positive provision for him in the light of this definition¹⁴. He also exposed some of the inadequacies of the rhetoric of South African psychiatry in that it claims to require knowledge of 'cultural' factors but was in this case unable to cope with them adequately. As staff we were effectively silenced by Mr B, and this took away our ability to provide a genuinely helpful environment for him.

The cases of both Ms A and Mr B demonstrate how the model of separate, bounded 'cultures' as used in South Africa can be of limited clinical value. In both cases there was a need to establish a model of understanding which incorporated both the clinician and the

'other culture' patient. Recognition of this second type of model, however, is potentially subversive of the socially constituted clinician-patient relationship in that it emphasizes their similarities rather than differences.

VII. Implications and conclusions

This chapter has traced some issues in the production of a culturally constructed (Gaines, in press) language of pseudo-relativism in South Africa and its relationship to conditions in South African psychiatry. I have demonstrated that the language of relativism plays a particular role within South African state strategy, in its academic disciplines in general and in psychiatry in particular. I have illustrated some ways in which 'relativism' can be used to reproduce certain stereotypical pictures of mental illness. These images in turn reinforce the 'reality' of images generated by the state. Case examples have illustrated how these issues are realised in clinical practice, and some of the questions and debates surrounding responsible clinical practice have been discussed.

Working in an unequal society like South Africa demonstrates the importance of taking account of power relationships. Knowledge, expression of distress, healing practices, are not all qualities of human essence which alters in appearance in certain contexts but remains fundamentally the same. When issues of knowledge are being explored, the question of value is not one that can be swept aside. Not all knowledge is equal.

The pseudo-relativist approach of the South African state does indeed take context into account, but only context of a particular kind. Context is reified into a cultural 'essence' that inheres within the patient - a product of belief in the primacy of racial categories. Other contexts which are deserving of more attention include the material context and the context of the clinical encounter.

Prejudice and discrimination which masquerade as relativism can be seen to be part of a discourse of domination, as Said's study of Orientalism shows, and, as I believe, is seen in South African psychiatry. The questions of power and resistance cannot legitimately be divorced from clinical practice. There is the constant reality that in defining patients clinicians are simultaneously defining themselves and their own position. 'Pure' knowledge of a patient's 'real' state of mind (i.e. divorced from this context) cannot be obtained. The task of building a South African psychiatry which takes adequate account of the different realities of patients - a psychiatry which Ngubane (in Kottler, 1988) would perhaps support - is severely impeded by the fact that 'difference' in this country almost invariably implies domination¹⁵. Adequate knowledge of a range of social practices remains however essential. Clinical practice itself as conducted by 'Westerners' is a social practice and part of the social fabric of South African life as much as is any 'traditional' healing ritual. The rest of this dissertation examines aspects of this clinical practice as an aspect of the functioning of South African society.

Notes to Chapter 4

1. Pêcheux (1975, as quoted by Macdonnell, 1986, p. 24) argues that 'words, expressions, propositions, etc., change their meanings according to the positions held by those who use them'. Clearly, the position held by South African psychiatrists has similarities with but also differences from those of psychiatrists elsewhere.
2. In making this distinction between theory and theory-in-use I wish neither to suggest that theory itself is developed out of a social context nor that arguments cannot be made for the inherent racist nature of the concept of cultural relativism. In what seems to be a misreading of the work of Littlewood and Lipsedge (1982), the Black Health Workers and Patients Group (1983) nevertheless make the more compelling general point that

...if a previous generation of psychiatrists regarded blacks as the problem, the new ethnic school views blacks as having problems. If the former sought to blame the victim by saying black genes were responsible for our individual oppression, the latter simply substitutes black culture as the same cause of our collective oppression.

(Black Health Workers and Patients Group, 1983, p. 54).

It is unfortunately beyond the scope of this dissertation to consider this position in detail; similar arguments by South African anthropologists will however be dealt with later in the chapter.

3. Gaines (in press, p. 2) argues that the term 'constructionism' has negative connotations: 'the term constructionism suggests coming to the study of lay and professional medicine, or any other domain of culture, with preconceived ideas. Such ideas constrain, limit and block understanding(s).' He suggests that the approach he terms 'cultural constructivism' is more useful in the medical anthropological arena than social constructionism. The negative connotations he sees as implicit in the term 'constructionist' are important in the text in question.
4. I discuss my own usage of the term 'discourse' later in this chapter.
5. Other notions, have of course been used (or misused) as well in the service of state ideology - including those of justice, fairness, and even democracy!
6. It should be noted that proponents of what Kottler (1988) terms the 'similarities' position do not set themselves up purely to produce knowledge questioning the South African state. Thornton (1988), like other contributors to the Boonzaier and Sharp (1988) volume, questions a range of received truths held by people from a wide variety of political perspectives.
7. It will be noted that this section is headed similarly to that in the previous chapter concerning the production of knowledge in relation to apartheid. This is deliberate, as the division between the areas covered in this and the previous chapter is made more for ease of presentation than on substantive theoretical grounds.
8. I do not suggest here that these three positions are historically distinct or even that they follow the order in which I have presented them. The schematization of 'state policy - "similarities" - "differences"' is however useful here as it illustrates some of the complexity of ideological forces impinging on ethnopsychiatric practice.
9. Thornton (1989) wittily remarks that 'The post-colonial condition means, increasingly, that there are fewer and fewer people who can be labelled simply "Them" without fear that they will also climb out of the undifferentiated sea of nature and demand a place under the pronoun "we".' (Thornton, 1989, p. 3).
10. This is the only work of Kleinman cited by Gillis et al (1989).
11. What they perceive to be best may, of course, be cast in racist terms.

Chapter 4: Relativism in South African psychiatry

12. This is in all probability a gross oversimplification of the epidemiology of hysteria (see Leff, 1988), but the fact that it was 'common knowledge' in the institution in question is an interesting piece of information in itself.
13. I have argued elsewhere that anorexia nervosa can fruitfully be understood under this rubric - see Swartz (1985a, 1985c).
14. Since the time of Mr B's stay a large psychiatric hospital chiefly for coloured patients has opened. Black patients alone are now treated on the formerly Black/coloured side of the older institution. This has led to far more cognisance being taken of the particular needs of and language spoken by Black patients. It is however interesting that in discussion of current moves to integrate all psychiatric facilities by race, concern is being expressed by some about the problem of white and Black patients' not being able to communicate with one another, or feeling 'culturally alienated' from another (see Chapter 10). I had no knowledge of this type of talk, which applies equally to communication gaps between coloureds and Blacks, when they were together for many years in the same wards.
15. The implications of the associations between notions of difference and domination extend beyond South Africa. Said (1985) is extremely disparaging about the argument that Arabs may indeed possess a true 'cultural essence' of which they may be proud:

...there has been a comic effort by some Arab nationalists to see the Orientalist controversy as an imperialist plot to enhance American control over the Arab world. According to this implausible scenario, the critics of Orientalism are not anti-imperialists at all, but covert agents of imperialism. The logical conclusion from this is that the best way to attack imperialism is not to say anything critical about it.
(Said, 1985, p. 9).

It is clear that Said is engaging here in an intellectual sleight-of-hand, and avoiding engaging with the substantive position of some of his critics. I do not have the space here to engage in further discussion on this issue, but it is interesting to note that the flourish with which Said (1985) supposedly demolishes a 'differences' position as regards Orientalism is not dissimilar to the style Thornton (1988) uses in his attack on the South African 'differences' position. In the concluding chapters of this dissertation I shall return to a consideration of this attack.

PART 2

PSYCHIATRIC WARD-ROUNDS

Chapter	Title	Page
5	Introduction	110
6	Ward-rounds in a psychiatric casualty unit	130
7	Ward-rounds on the 'Black side' of Eagle's Nest Psychiatric Hospital	146

Chapter 5

Introduction to Part 2: the study of psychiatric ward-rounds

Table of contents

I.	Background information	111
II.	The study of psychiatric ward-rounds	112
A.	Theoretical background	112
1.	The macrosocial approach	112
2.	The microsocial approach	113
3.	Combining microsocial and macrosocial levels	116
B.	The psychiatric ward-round	120
III.	Method	123
A.	Settings	123
B.	Data recording	124
C.	My role in the ward-rounds	124
D.	Selection of material for presentation and analysis in the dissertation	125
	Notes	127

Chapter 5

Introduction to Part 2: the study of psychiatric ward-rounds

I. Background information

This part of the dissertation presents findings and discussion of my attendance at ward-rounds at different points in a psychiatric system. This system is a network of hospitals, hospital units and centres, all of which fall under the aegis of the Department of Psychiatry of a large English-medium South African university¹. Some are funded by the South African state health coffers, some by the Province (the region of South Africa in which the university is situated), and some by the health budget of the House of Representatives (which provides hospital services primarily for 'coloured' patients). All academic staff in these settings (psychiatrists and psychologists) are employed in terms of a tripartite agreement between the university, the (state) Department of Health, and the health services division of the Provincial Administration. Psychiatrists are in charge of all units and answerable to the Department of Psychiatry of the university.

Because one of my chief interests is the way in which Black patients are perceived by staff, I chose to examine the two key settings in which they are treated: the racially integrated psychiatric casualty (emergency) unit of De Hoop Hospital (a general teaching hospital serving the region) and the Percelia side (also known as 'the Black side') of Eagle's Nest Hospital, which caters exclusively for Black patients.

The structure of the local state-funded network of psychiatric units and hospitals is presented in Appendix A. For purposes of this part of the dissertation it is important to note that all the units are administered from the psychiatric service point of view as interrelated entities. It is thus the case that by far the majority of patients at Eagle's Nest Hospital, for example, both white and Black, and those at Spring Valley Hospital (largely coloured patients), first enter psychiatric care at the Psychiatric Casualty unit of De Hoop

Hospital². Any discussion of the local hospital system for psychiatric patients (referred to as 'the hospital system' henceforth in this dissertation) immediately raises further questions about apartheid health services, and the division of these by race (De Beer, 1984). These questions were dealt with more generally in the first part of this dissertation, but specific issues about the racial structuring of services will emerge in the course of discussions of ward-rounds in different settings. As this part of the dissertation deals with in-patient facilities, and since it is in the context of such facilities that the data were collected, little attention will be given to out-patient or follow-up community clinics.

II. The study of psychiatric ward-rounds

A. Theoretical background

Two related traditions of research in the social organisation of medical and psychiatric practice are easily identifiable in the literature. Each will be briefly discussed as it impinges on the present study.

1. The macrosocial approach

What may be labelled the macrosocial tradition has concerned itself with broad issues in health service provision, the economics and politics of illness and health care delivery, and the functioning of health institutions within the concert of related state structures and organisations. Included under the macrosocial umbrella would be work such as that of Navarro (1976; 1986) on the political economy of health care, Brenner (1973) on mental health and the economy, and work in the 'critical' psychology and psychiatry schools. Particular focus in this literature has been on the role of psychiatry as a vehicle of social and political regulation (Ingleby, 1981a, 1988; Miller & Rose, 1986, cf Mechanic et al, 1976). South African research on the social and political organisation of health care has tended to focus on macrosocial questions, the central one being that of the distribution of health and mental health resources in the apartheid state (e.g. Dawes, 1985; De Beer, 1984, 1986; Owen, 1988, 1989; Solomons, 1980; Vogelmann, 1986; Wilson & Westcott, 1980).

Central though macrosocial studies are (and, arguably, particularly so in South Africa), the issues they raise beg the question of how the power relationships they have identified can be observed within the clinical setting itself. How do clinicians, patients, and other players in the health care arena respond to, reproduce, question or even sabotage and undermine the pattern of unequal social relations into which they are inserted? That South African health and mental health services are racist at the structural level has been well established (SAIRR, 1988, pp. 792-812, collates some of the more recent figures on disparities in expenditure on health by race). If figures do not give an adequate sense of discrimination, in the particular context of the current study, one needs merely to walk or drive from the Orange Grove (white) side of Eagle's Nest Hospital to the Percelia (Black) side to be convinced that there are gross disparities in the age, type, and state of repair of the buildings, the quality of the roads and the upkeep of the gardens. To some extent the interesting question in South Africa is no longer whether or even to what extent discrimination exists at a structural level (these have been answered more than adequately), but how a supposedly colour-blind and impartial discipline like medicine (Lock & Gordon, 1988) functions in this context. A more specific question, central to the rest of this dissertation, is the following: Given that such discrimination does exist at the macro- level in the psychiatric system under examination, how does this realise itself in everyday psychiatric practice and in the ways that clinicians see themselves, their patients, and their practice³? For aspects of this question to begin to be addressed it is necessary to examine microsocial approaches to research as well.

2. The microsocial approach

Introducing an influential text in this area, Mishler (1984) notes:

Although problems of physician-patient relationships receive a good deal of discussion, it often takes the form of rhetoric, exhortation, and policy pronouncements rather than of analysis based on direct observation of doctor-patient encounters. Alternatively, characteristics of the relationship may be inferred from studies of the economics of health care or the social

organization of health care systems. Until relatively recently, there were few studies that systematically examined medical interviews as loci of realization of these relationships. (Mishler, 1984, p. 8).

One of Mishler's central concerns is that of what constitutes what he terms a 'humane practice' (p. 6). He demonstrates that in order for the issue to be addressed adequately it is necessary that we do not simply resort to 'rhetoric' (p. 4) and 'exhortation' (p. 4) to clinicians that they must behave as better people. Nor, on the other hand, must we believe that the complexities of medical practice can be adequately captured from the data of macrosocial studies, useful though such data may be. If we are serious about 'humane practice', Mishler would argue, we need as disciplined an understanding as possible of the minutiae of doctor-patient contact.

Some South African examples will serve to illustrate the limitations of both the 'exhortation' approach criticised by Mishler, and of inferring about the microsocial level from the macrosocial. A recent South African paper which makes use of what may be termed the 'exhortatory fallacy' is that of Levenstein (1988). In arguing for a more democratic relationship between white doctors and Black patients, Levenstein calls for a mutually respectful relationship between doctor and patient, and one in which the doctor is prepared to give up some of his/her socially constructed power. We have discussed Levenstein's approach at some length elsewhere (Swartz, Gibson & Swartz, in press), and it is sufficient for present purposes to note three points:

1. Unlike an approach which examines practice more closely, Levenstein's method does not allow for the exploration of struggles for power in medical settings between clinician and patient.
2. The macrosocial phenomenon of rapid social upheaval and state repression may well be a factor having an effect on social relations in the clinical setting, particularly where clinicians are of progressive political views, as are members of

Levenstein's implied audience. Few, if any, of these clinicians are likely to be unaware of their own location as middle-class professionals in the context of rapid social change. Levenstein's 'exhortatory' approach, then, suffers from insufficient attention to the macrosocial level⁴.

3. Levenstein ignores the fact that there are many theories concerning the nature of power, its use and abuse (Simkins, 1986). Accompanying this oversight is the fact that Levenstein insufficiently problematises the concept of the doctor-patient encounter as an area for study.

In the mental health field in South Africa, as was seen earlier in this dissertation, a number of authors have criticised practice on 'macrosocial' grounds - largely on the basis of maldistribution of resources by race (Dawes, 1985; Solomons, 1980; Vogelmann, 1986). As I have mentioned before, there can be no doubt of the value of such approaches, but in the absence of an analysis which includes detailed examination of the microsocial level, these studies tend to leave a somewhat unidimensional impression of the image of the South African clinician. This is a picture of a power-hungry, racist person more concerned with the accumulation of wealth than with the needs of clients and patients⁵. Such people may indeed exist, but would be unlikely to identify themselves in such unflattering terms. Furthermore, the fact that the person of the individual clinician may be either effaced from macrosocial analyses or by implication (even if not by design) lurking in the background as a malevolent state agent has an important cost. It weakens the potential of purely macrosocial approaches to play a part in changing clinicians' behaviour. It is difficult for clinicians to identify themselves as evil, and if they do so they may be likely to be so paralysed by guilt that they are unable to change. It is similarly difficult for clinicians to relate the macrosocial level of analysis to what they do in their daily work⁶. Clearly, South African work able to explore the microsocial level is needed.

Since around the time that Mishler was writing, much has been written about medical and psychiatric interviews from a range of theoretical perspectives. Studies of psychiatric and medical discourse have tended to focus on the minutiae of dyadic doctor-patient interaction, and have concerned themselves, amongst other things, with how power is negotiated in the clinical setting (see for example Fisher & Todd, 1983; Good & Good, 1981; Lock & Gordon, 1988; Silverman, 1987; Strong, 1979; Swartz & Swartz, 1987; Turner, 1987). Early contributions from the anti-psychiatry movement, furthermore, had provided detailed descriptions of encounters between psychiatrists, patients and their families (see for example Laing, 1960; Laing & Esterson, 1964), and raised issues of power. This anti-psychiatry tradition, however, has been criticised for having a rather naïve concept of power and power relations, and for subscribing to what amounts to a conspiracy theory of power (Ingleby, 1981b). More sophisticated analyses of questions of power in psychiatry - notably those of the 'critical' psychology and psychiatry school - have, as we have seen, in general abandoned examination of the details of the clinical context in favour of consideration of the broader issues of the nature of the discipline of psychiatry as a whole. Clearly, the link between observations of everyday practice and talk about broader issues of power and macrosocial organisation is not necessarily easy to make. It is equally clear however that such a link is necessary if microsocial approaches are to offer more than what Kuipers (1989, p. 110) has called 'a quick linking of a few lines in a transcript with an ideological statement' (cf. Atkinson, 1988b; Waitzkin, 1989).

3. Combining microsocial and macrosocial levels

Recent attempts to develop what has been termed 'critical medical anthropology' all grapple with ways of exploring links between clinical encounters and experiences and the operations of the state (Frankenberg, 1988; Kaufman, 1988; Morsy, 1988; Singer, 1989; Singer, Davison, & Gerdes, 1988; Van Binsbergen, 1988). A criticism that has been made of the work of some proponents of the 'critical medical anthropology' approach is that it attacks hermeneutic approaches unnecessarily. Csordas (1988) sees as

dangerous...the radical schoolishness that assumes that culture and political-economic analyses are mutually exclusive and that only the latter can be critical, when they are more fruitfully understood as complementary 'takes' on multiply determined problems. (Csordas, 1988, p. 418).

In defence of his position, Csordas (1988) cites the compelling analysis by Good and Good (1988) of the relationship between the state and emotional discourse in Iran, which unites discussion of the personal and the macrosocial levels without overt recourse to critical theory. A second criticism of critical medical anthropology lies in the direction of arguing that the approach offers little more than a type of sophisticated demonology - a search for evil manipulation and 'culprits' (Estroff, 1988):

The critical medical anthropologist's task seems to consist of providing the evidence that indeed Western capitalism, and its evil sidekick biomedicine, have hegemonized (or is it homogenized?) most of the world that we can discover - the remainder to be infected, penetrated, and disrupted, all in due time. Description and analysis devoid of accusation will simply not do; etiology includes blame these days. (Estroff, 1988, pp. 421-2).

Another version of this criticism, more fully grounded in an appraisal of the social use of Marxist theory, raises questions in a slightly different way:

But does Frankenberg's rehabilitation of the notion of hegemony, though reinterpreted, not risk restoring conceptions of an imperialistic, oppressive capitalism and of the ultimate nature of economic factors - in short, conceptions limited to explaining by reference to dominant groups that seek to manipulate and mystify the oppressed? How, since Foucault, can we conceive of social relations in such a negative, voluntarist way? Can we ignore the fact that power is not necessarily a 'substance' that issues from the conscious will of those 'above,' but that power relationships and their underlying representations are set up and worked out through the daily management of face-to face relationships - in other words, at a level where various axes of super- and subordination are used in various contexts so that the outcome of any given event is not necessarily decided a priori? (Sindzingre, 1988, p. 449).

A full discussion of the debates between 'critical' medical anthropologists and others is not necessary to the present argument. What is important, however, is that there is general agreement that research which links micro- and macro- levels of analysis is necessary. There are at least two major pitfalls to avoid in such an enterprise. The first is that of losing the benefits of interpretive approaches which may or may not have set themselves the primary task of linking such levels of analysis, and the second is that of resorting to a

crude conspiracy theory of power (similar, indeed, to that of some antipsychiatry approaches, as discussed earlier).

There are many possible obstacles in the way of addressing the question of the relationship between actual clinical practice and broader issues of power. The most important of these for purposes of the current discussion may be an implicit and unquestioned definition of the clinical setting as, quintessentially, that of the consulting room occupied by the clinician - in the case of the current study, the psychiatrist (Atkinson, 1988b; Lazarus, 1988)⁷. To talk in the same breath about what happens in the relationship between one psychiatrist and one patient, and about psychiatry as a social institution may seem very difficult, and demanding of an enormous breadth of scope. If, however, the context of any clinical interchange is viewed broadly (Swartz & Swartz, 1987), and it is further recognised that the clinical domain includes the world of hospital passages, hallways, lobbies, and even toilet facilities, then the link between talk of the clinical domain and talk of psychiatry as a discipline of social regulation becomes easier to make.

Estroff's (1981) study of psychiatric patients living in the community highlights, among many other things, the arbitrariness of defining day-to-day psychiatric practice as centering on the dyadic clinical encounter. More recently, studies of both psychiatry (Good et al, 1985) and forms of healing outside the biomedical context (Brown, 1988) have emphasised the fact that the dynamics of clinical power occur in a context informed by a complex web of relationships which go beyond the level of the interaction between two individuals. Barrett's (1988) detailed examination of the process of the construction of schizophrenia through case notes shows that it is indeed possible to observe macrosocial processes at work in the everyday details of psychiatric work, and to discuss them in a way which does not lead to trivial generalisations. Kuipers (1989) suggests that an essential feature of making a link between micro- and macro- features in the study of medicine is the recognition that there is a process relationship between the level of conversation on the one hand and the level of the institution on the other (cf. Lazarus, 1988)⁸.

It is interesting in this regard that two notable recent attempts to explore the interface between micro- and macro- levels of understanding, differing though they do in important respects, share the common feature of the reproblematisation of apparently everyday concepts. Good and Good (1988) abandon received notions about 'depression' as a bounded diagnostic entity, paving the way for their discussion of emotions and the state in Iran⁹. Similarly, Scheper-Hughes and Lock (1987) engage in the question of the relationship between individual experience and social and political structures by demonstrating how the apparently 'natural' entity of the body is constructed through a range of discourses.

In order to deal with some questions about the relationship between details of clinical practice and the politics of both mental health care delivery and of the creation of identities in South Africa, it has been similarly necessary for me to problematise the fundamental 'given' of 'clinical practice' as mentioned earlier. As Barrett (1988) and other theorists have shown (see, for example, Goffman, 1961 for his classic study of the rules of the asylum), to view the site of psychiatric care and control as in essence, that of the dyadic clinical session, is to ignore the extent to which even the boundaries of that session are constructed through dominant notions about psychopathology and its treatment (cf Light, 1980). I hope to demonstrate through presentation of some data about psychiatric ward-rounds, furthermore, that clinical psychiatric practice resides not simply in talk *to* patients, but also in talk *about* patients (cf Anspach, 1988; Brown, 1987). In Foucault's terms, the study of clinical psychiatric practice lies not only in an examination of the clinical 'gaze' (Foucault, 1973), but also in the role of that gaze in an 'incitement to discourse' (Foucault, 1985) about psychiatric patients in a particular and structured way.

A second way in which this study of psychiatric ward-rounds relies on a reformulation of accepted ideas is that it examines professional discourse and practice not as entities disjunctive from everyday life but as part of the very social fabric which constructs the idea

of professionalism¹⁰. In this respect, I follow recent trends in medical sociology and anthropology and in other disciplines (Abbott, 1988; Antaki, 1988; Hahn & Gaines, 1985; Lock & Gordon, 1988; Louw, in press; Swartz, 1986b, 1988), and, notably for this discussion, that of Kleinman (1988a).

In summary, it may be said that the first task of any study which attempts to link the macrosocial and microsocial levels is to explore the extent to which firstly, the distinction itself is a social construction, and secondly the ways in which at either level certain aspects are overlooked. By defining the microsocial level (explicitly or otherwise) in particular as purely the level of contact between the doctor and the patient, one is likely to encounter difficulties in making links with the macrosocial level, precisely because the very idea that it is the doctor-patient relationship which defines the microsocial level is a social construction - a construction easily related to broad social concerns about the division of power.

B. The psychiatric ward-round

It is clear that there has thus far been no critical study of the functioning of issues of culture, race and oppression in day to day South African mental health practice. This dissertation represents the beginning of such a study. I focus in this part of the dissertation on the operation of psychiatric ward rounds because, as I demonstrate below, the ward-round offers the opportunity for observation of a large range of factors, including relationships between staff and patients and relationships amongst staff members themselves.

In their studies of ward-rounds and case conferences, medical sociologists have tended to examine these events as mechanisms of social control within the medical system, focussing chiefly on control of clinical staff, patients, and relatives (Anspach, 1988; Arluke, 1980; Brown, 1987; Corbett, 1986; Frader & Bosk, 1981; Prince et al, 1982). In his study of the professional socialisation of psychiatric residents, Light (1980) examines the role of the

case conference in the shaping of residents' perceptions to those of the psychiatric hierarchy. An important feature of ward-rounds for purposes of the present study (and particularly in the light of the interview material to be presented in Part 3) is the fact that such occasions often represent sites of multiple transformation. Patients' stories are changed into 'case histories' and the patients themselves into embodiments of diagnostic categories (cf. Barrett, 1988). Staff who are 'presenting' patients to rounds are often trainees who in the process of presenting patients are also presenting themselves to the group as part of their own process of transformation from trainee to qualified clinician. Close observation of ward-rounds, therefore, can provide information both about how patients are seen and about organisational culture.

The term 'ward-round' covers a range of practices, as will become clear later, but ward-rounds in the system I studied do share common features. The term 'ward-round' comes from general medicine, and is generally but not always accurately taken to refer to a situation in which clinical staff tour the ward examining and discussing patients. The ward-round constituted in this way offers excellent opportunities for more experienced clinicians (typically, specialist consultants, in a teaching hospital) to check whether the clinical diagnoses of more junior staff (registrars, medical officers, interns) were correct. Teaching at a practical level can be undertaken at the patient's bedside, techniques observed and demonstrated.

A cardinal difference between a psychiatric ward-round and those described above is that staff in a psychiatric ward-round do not move about. Instead, clinicians¹¹ gather behind closed doors and those primarily responsible for patients report on them, generally reading from folders¹². Patients may or may not be called in to be interviewed during the ward-round itself, depending on the nature of the problem discussed, but more particularly on the rules of the particular type of ward-round. For example, in the rounds I attended in a general hospital psychiatric casualty (emergency) unit (Psychiatric Casualty at De Hoop Hospital), I did not witness a patient's being called in to be interviewed; in those in the

Black admission wards of a psychiatric hospital (the Percelia or Black side of Eagle's Nest Psychiatric Hospital) patients were almost always called in.

There are a number of possible reasons for the psychiatric ward-round's not being an actual tour of the ward - the history of the sedentary 'ward-round' would be interesting in itself but will not be dealt with here. Two points about the sedentary nature of the round do need to be made, however. Firstly, psychiatric patients are generally ambulatory. A trip around a ward to see people who are not confined to bed would seem rather odd - especially in view of the status relationships implied in arranging for someone to attend one's meeting as opposed to going to see that person¹³. Secondly, and more importantly, psychiatric talk is not like the talk of general medicine. The language clinicians use in their talk about patients, although highly structured and rule-bound (Barrett, 1988), is not as different from everyday talk as the jargon, say, of surgeons. The language, furthermore, of professional psychiatry both mirrors and is reflected in everyday discourse (Swartz, 1987a). Practitioners of general medicine have been shown to label their patients and make moral judgements about them (Stein, 1986); this labelling process may be viewed as to some extent incidental to *medical* talk about 'disease' as opposed to 'illness'¹⁴, but in clinical psychiatry the talk cannot but centre on psychosocial aspects of illness. In terms of content, there are some similarities between clinicians' talk about patients and gossip - both forms of talk focus on information about people which is interesting partly because it is generally labelled 'private'¹⁵. There are further factors in the construction of psychiatric talk in such situations which require privacy from the patient. These include the belief that aspects of professional knowledge are potentially damaging to the patient¹⁶, concern with confidentiality¹⁷, and fear (often legitimate) of the potential reactions of patients to discussions about themselves.

In the chapters that follow I present and analyse some case material gleaned from my attendance at ward-rounds within the same psychiatric hospital system but at different points in this system. It will become clear from the material presented that I have chosen

to examine two types of ward-round very different from each other, but it should be noted that both of these rounds are integral parts of the larger whole which is institutional psychiatric practice in the hospital system under examination. First, in Chapter 6, I present and discuss findings based on my attendance at ward-rounds in the psychiatric casualty unit. This unit represents the point of entry for many patients in the hospital system; it is a continuous service which provides in-patient facilities for relatively few patients and serves mainly as a clearing house in the routing of patients to other, longer-term units. A primary decision facing a clinician working in this casualty department is whether the patient needs to be admitted to hospital at all; within a few days at most a further important decision concerns where the patient should be transferred to. The casualty unit in question is completely integrated racially with respect to staff and patients; there are separate sleeping facilities for male and female patients. The second type of ward-round I discuss (in Chapter 7) is in the inpatient wards on the side of Eagle's Nest Psychiatric Hospital reserved for people classified as 'Black' according to the Population Registration Act. These wards are segregated with respect to patients along gender lines and represent the sites where treatment of patients is undertaken. Although there is some movement between wards on this side of the hospital, none of the wards is regarded simply as a clearing-house and all of them are units where patients are treated and the vast majority finally discharged usually for follow-up treatment at community clinics or the hospital out-patients department¹⁸.

III. Method

A. Settings

I attended ward-rounds in the psychiatric casualty (PC) department of De Hoop Hospital three times per week in the second half of 1987. These meetings took place at the beginning of the working day and generally lasted half an hour or less. They were attended by all clinicians working office hours on the unit¹⁹ who were not at the time engaged with other clinical or teaching responsibilities, trainees, and sometimes other clinicians²⁰. From September 1987 to the end of 1988 I attended weekly ward-rounds on the Black side of

Eagle's Nest Hospital. These rounds lasted an entire afternoon (between two and three hours, including a break for tea and cake). They had the status of being special in that they involved joint discussions by staff of a variety of units on that side of the hospital, were in addition to ward-rounds within the units themselves, and involved presentations to and teaching from a visiting consultant. In this case the consultant was either the Head of the Department of Psychiatry or a psychiatrist who is an acknowledged authority on transcultural psychiatry; sometimes both these consultants attended.

B. Data recording

In both settings I took notes using a pen and pad. This clearly limited the amount that I was able to record and also opens my selection of data to allegations of bias. I had unfortunately not been granted permission to use tape recordings at these ward-rounds. I decided against the use of checklists because these would constrain me from obtaining qualitative data structured in ways I might not anticipate²¹.

C. My role in the ward-rounds

Although I attempted to be as unobtrusive as possible in the ward-rounds, I was clearly in a more complicated position than the proverbial 'fly-on-the-wall'. In explaining my research to participants and asking their permission to be present I described the outline of my research in broad terms, mentioning that I am interested in the workings of professional psychiatric culture. I discovered as time passed that this was open to many interpretations. For example, one person believed that I was evaluating adequacy of referral to other units when in fact I had no method to begin to address this complex question; another found it difficult to believe that I could see anything in what was happening. My position was further complicated by the fact that I was reasonably well-known in the department concerned, having trained there myself and having worked as a researcher in the department for some years. Amongst the people I was observing were former teachers, supervisors, colleagues and students of mine. It should also be added that a number of

people with whom I worked during this time mentioned to me that I was known in the department as a person with strong and sometimes controversial views; some of the people had read material I had published or had attended talks I had given.

My constant presence at the ward-rounds went some way, I hope, to lessen the impact of my position as observer on the behaviour of participants in the rounds. In both settings I felt that I settled quickly into being an accepted feature of the everyday life of the unit. The influence on my interpretations of my own feelings about being this observer, however, is more complex and difficult for me to assess²². Reflexivity is clearly a central issue in the interpretation particularly of clinical material of this kind, and I have considered how I am positioned in relation to my interpretations throughout (cf Good et al, 1985; Levett, 1989; Peshkin, 1985).

D. Selection of material for presentation and analysis in the dissertation

I make no claim that what I present in the following two chapters is statistically representative of what occurred during the ward-rounds I attended. I have chosen to present material here which for me highlights some of the interesting features about the construction of aberrant behaviour and its translation into 'mental illness' in the settings in question. My choice of material for presentation is driven, then, by theory and I cannot claim 'proof' of my views in the sense generally accepted in experimental psychology²³.

The fact that I have been selective in my reporting affords me the opportunity to provide detailed material for discussion and to highlight what I perceive to be central questions. In the process of selecting, however, I cannot but lay myself open to charges that I am overlooking features which would lead to a different type of analysis. This is undeniable, and the argument that this is a common method of presentation²⁴ does not in itself constitute a defence.

My chief concern in this part of the dissertation is not to give an overview of ward-round practices but rather to elucidate areas which have particular bearing on the questions underlying the entire study. At no point do I claim that a single incident or example can be said to stand for everything that occurs, and statistical-type generalisation from the single case to the whole is never claimed here. A major interest of mine in reporting on ward-rounds is to isolate instances where rules are made explicit by their being broken. Discontinuities and conflicts about patients, as well as rule-breaking, may offer particular scope for elucidation of institutional rules, which may in turn be considered in the light of macrosocial structures (cf Garfinkel, 1967; Harré & Secord, 1972). My experience in Psychiatric Casualty, furthermore, represented for me the breaking of another implicit rule of South African transcultural psychiatry, and, indeed, South African psychiatry in general - the apparently self-evident 'fact' that patients' different racial or cultural backgrounds constitute and contain the major challenges for South African practitioners. By presenting and discussing case material, I am able to throw light both on the transcultural psychiatry literature reviewed earlier and on the interview material of Part 3. A strategy more concerned with statistical generalisability would inevitably, within the space available, detract from maintenance of clear foci in the dissertation as a whole.

The remaining two chapters in this part of the dissertation present and discuss results of my attendance at ward-rounds in Psychiatric Casualty (Chapter 6) and on the Black side of Eagle's Nest (Chapter 7). The closing section of Chapter 7, in addition, explores issues raised by the discussion of rounds in both settings.

Notes to Chapter 5

1. All names given to units and people within this system henceforth in the dissertation will be pseudonyms, for reasons of confidentiality.
2. There are some exceptions, including forensic patients referred by the courts for observation for ability to stand trial, readmitted patients well-known to the psychiatric hospitals' out-patient departments and who present themselves for care during office hours, and, increasingly since my study was completed, coloured patients making use of fledgling psychiatric casualty services at Spring Valley itself.
3. At this stage, clearly, I am asking this question in very broad terms, and it cannot be answered in its entirety. As the dissertation progresses, particular aspects germane to the question will be addressed.
4. Another way in which the macrosocial level is ignored by Levenstein is through his apparently viewing as neutral (or, as simply 'humane') the person-centred approach to psychotherapy as advocated by Carl Rogers. That Rogers was not neutral with respect to South African issues, probably through lack of familiarity with the complexities of South African society, was clear in his decision to visit this country and while here to associate himself with a member of the South African Defence Force (Swartz, 1986a).
5. I should make it clear that this image has not been intentionally created by the authors cited, but it is a powerful picture related strongly to images of South African psychiatry and psychiatrists reviewed earlier. This unfortunate image also informs one of the more eloquent rebuttals of critical approaches to South African psychology (Biesheuvel, 1987).
6. It is possible that this observation may be read by some to be patronising about clinicians. This is not my intention. I myself am a clinician who struggles with trying to identify the impact of macrosocial factors on my clinical work. More importantly, perhaps, as I demonstrate later in the chapter, the linking between the microsocial level and macrosocial levels remains an important theoretical problem area in general.
7. This image of the clinical setting as essentially the domain of a dyadic relationship between doctor and patient reproduces dominant views about biomedicine as a discipline centrally concerned with the individual, and with privacy and confidentiality. I return implicitly to this issue in the presentation of findings concerning ward-rounds.
8. Kuipers's (1989) analysis of what is necessary for such a study includes specific reference to conversational analytic approaches which for a variety of reasons - not least of which is the fact that I was not permitted to tape ward-rounds - I shall not be using here. His general points are, however, relevant to the analysis I present in the dissertation.
9. This reproblematisation of the notion of depression is of course fundamental to many of the more innovative current approaches to the area - see, for example, Kleinman and Good (1985).
10. This issue is returned to at slightly more length in Part 3.
11. I use the term *clinician* here and elsewhere to include psychiatrists, clinical psychologists, social workers, occupational therapists, nursing sisters and trainees in all these fields.
12. In some therapeutically-oriented units, some joint ward-rounds take place in which all staff and all patients are present; these units were not examined in this study. It should be noted however that all units within the local system have ward-rounds which patients do not attend except when they are specifically called in during discussions about them.
13. These relationships are clearly modified when the patient is unable to move or confined to a circumscribed area through sickness or medical treatment.

14. There are different approaches in medical anthropology to the disease-illness distinction (Young, 1982), and the debates concerning the distinction and its utility will not be entered here. For purposes of the current discussion it is sufficient to recall the definition of disease as the pathophysiology of any disorder, and illness as the social experience of disorder (Kleinman, 1977). It is possible to have disease without illness (as in the case of having a tumour of which one is unaware) and illness in the absence of disease (as in the case of what the American Psychiatric Association, 1980, would term factitious disorder). The extent to which it is possible to have a psychiatric 'disease' is debatable given the importance of psychosocial factors in psychiatric disorder. Much of the project of modern biological psychiatry, however, can be seen as an attempt to delineate psychiatric disease. Recent formulations on the disease/illness distinction as applied to psychiatry identify disease not with pathophysiology but with the categories constructed through psychiatric diagnostic instruments, inventories, and manuals (Barrett, 1988; Kleinman, 1988a, 1988b).
15. I am not trying here to suggest that clinicians talk about patients necessarily with malicious intent. Both gossip and psychiatric ward-round talk (apart from much of what is said when a patient has been invited into the ward-round), however, are most fundamentally talk about someone else, and often about 'secrets' of some kind. The importance of secrets is greatly increased in the light of the influence of psychoanalytic theory. This theory deals with the unconscious, knowledge of which is by definition not available to the patient. The relevance of this to the current discussion will become clear later. It is beyond the limits of this study to explore the issue of gossip and psychiatric talk in more detail, but Forrester's (1984) comment that 'People like hearing about psychoanalysis' (p. 153) is relevant here, especially in view of his reading of Olinick's (1980) work on the 'gossiping analyst'.
16. For an analysis of some power dynamics inherent in the belief that clinicians have the potential to harm, see Swartz (1986b) who discusses issues of professionalism in South African psychology.
17. The idea of honouring confidentiality by keeping information even from the patient concerned is not as strange as might appear. Psychiatric practice relies heavily on accounts about the patient by family members, colleagues, and so on, and clinicians are often entrusted with information and secrets which if revealed would compromise the confidentiality of their relationships with these informants. There is also the issue, of course, of keeping information about patients from other patients. In all units which I have attended nothing is revealed to other patients without the permission of the patient in question, and the staff decision about what should be revealed, should the patient agree, is explicitly based on a consideration of what would be in the interests of the patient and others.
18. During the period of my attendance at these ward-rounds, a neuroclinic (defined below) was reopened on the Black side of the hospital. This unit had closed some years earlier when the coloured patients who had formerly shared this side of the hospital with Black patients were sent to Spring Valley Hospital. This reopened neuroclinic is integrated with respect to the patients' gender (except insofar as sleeping accommodation is concerned) and is, unlike the major admission wards, 'open' (patients are not kept under lock and key). After the ward reopened, the ward rounds on the Black side of Eagle's Nest were conducted at the neuroclinic. The rounds also changed partly in focus: most of the presentations now concerned patients either in or eligible for this neuroclinic.

A 'neuroclinic' as the term is used in the local system is an open admission ward offering a variety of therapeutic services such as group and individual therapy, family therapy, art therapy and so on, along with medication. Patients generally speaking are classified neurotic or personality disordered, though psychotic patients whose behaviour is not disruptive are also treated in such a setting. A 'neuroclinic' is seen as distinct from a 'therapeutic unit', which caters for non-psychotic patients who are designated 'higher functioning' and has a far stronger emphasis on psychotherapies and less on medication.

The issue of which patients go where according to race and diagnosis cannot be discussed in any detail here, but it must be noted that matters are more complex than would appear from the crude application of psychiatric labels or race categories. For example, at the time of the study, Spring Valley Hospital, although officially set aside for coloured people through its being administered by the (coloured) House of Representatives, had an explicit policy of taking patients of all races and did admit white and Black patients, as did other such 'coloured' institutions (Savage, 1987). The racially separate

Chapter 5: Introduction to the study of ward-rounds

nature of each of the sides of Eagle's Nest ('white' and 'Black') and Spring Valley ('coloured') was however in general preserved.

19. Nursing staff on night duty or psychiatric registrars (trainees - equivalent to the US term 'residents') who do night and weekend casualty duty on a rotational basis do not attend.
20. These included clinicians who were involved with particular patients; and medical practitioners about to emigrate to Canada and who needed extra time in a psychiatric casualty unit in order to qualify to practice there.
21. The issue of qualitative data recording is given more attention in the introductory chapter to Part 3 of this dissertation (Chapter 8).
22. Complexities of interpretation do not of course end within the confines of the ward-rounds I attended. In writing this dissertation, for example, I have been, as would be anyone else doing so, very much influenced by considerations of how what I have to say will be received by what I construe to be different sectors of my potential audience.
23. This does not mean however that questions of validity have not been considered. These are central to current debates in qualitative research methods (see, for example, Huberman & Miles, 1985; Ricoeur, 1977) and must in any final analysis be taken into account. Issues regarding the validity of qualitative data are considered more fully in the introduction to Part 3 of the dissertation (Chapter 8), where the question of using quantitative techniques and the ways in which these are to be used have more direct salience.
24. A perusal of journals which have heavily influenced this study, for example, *Culture, Medicine and Psychiatry*, *Medical Anthropology Quarterly*, and *Social Science and Medicine* will show that many articles present case material and draw conclusions from this without any explicit consideration of the representativeness or typicality of such data.

Chapter 6

Ward-rounds in a psychiatric casualty unit

Table of contents

I.	A description of PC and PC ward-rounds	131
II.	PC and medical marginality	133
III.	Talk about 'race' in PC	136
	A. The relevance (or otherwise) of race and culture to PC	139
IV.	Concluding comments	141
	Notes	144

Chapter 6

Ward-rounds in a psychiatric casualty unit

I. A description of PC and PC ward-rounds

This unit (referred to as PC in the rest of this dissertation) is located in De Hoop (General) Hospital and consists of a male and a female ward with an approximate total of 10 beds, a nurses' station with glass panels providing a view on to the patients' sleeping areas, toilet and bathroom facilities, an office each for a psychiatrist, social worker, clinical psychology intern, psychiatric registrar, ward clerk and chief nursing sister. In practice, the clinicians' offices are used by different people at different times depending on who is working on the ward at the time; ward rounds are held in one of these offices. Long benches are provided in the passage for patients and their relatives; it is rare to find these benches empty at any time during office hours, and not uncommon to see many people having to stand while they wait for their interviews with clinicians. A hospital security guard when not engaged in other duties usually sits in the passage with his walkie-talkie. PC is situated at the convergence of two orthogonal passages, one leading to the basement of the general hospital and another to the medical casualty unit, which fronts onto the parking area for ambulances. The trauma casualty unit is situated in a separate part of the hospital. The route from the road through Medical Casualty to PC is circuitous; it took me some time to learn to walk through Medical Casualty to PC without making a wrong turning¹. Access from the main hospital basement is easier, but a large sign on the double doors which separate PC from the rest of the hospital denies access to people other than staff, and notes that the ward is not a thoroughfare. As PC is in the basement of the hospital many of the rooms do not have windows; the windows that do exist are high up and offer no opportunity for looking outside. During the time that I was there, the hospital was in the process of being renovated and in fact PC was due to move to a new building. The effect of these renovations was that at no time during my visits to the unit was PC free from the noise of power drills or walls being broken down. The sometimes deafening noise meant that

discussions in ward-rounds often had to be shouted or interspersed between banging noises².

The patient complement in PC is diverse. A study of admissions in March and April 1988, which staff in the unit take to be typical for the unit, revealed a range of conditions treated³. The pattern of admissions by race is changing, with a steady increase of the number and proportion of Black patients' being seen (Van Schalkwyk et al, 1989)⁴.

In order to be admitted to PC by oneself, by relatives, by a medical practitioner, by police or anyone else, one generally first has to be cleared of medical disease by the staff of Medical Casualty. An exception to this is when the patient has been referred from another hospital where a full medical assessment has already been made.

Morning ward-rounds in PC are for purposes of discussion of patients who have been admitted to the unit as in-patients, often the night or the weekend before. The decisions made in these rounds are generally in the nature of 'dispatches', as a member of the staff there informed me they are often called. These are decisions about where to transfer the patient, or about what types of assessment need to be made to facilitate referral or discharge decisions. Time spent discussing any single patient is extremely brief - of 120 discussions of patients the time of which I recorded, the mean time spent discussing the case (including reading aloud from case notes in the patient's folder) was 2 minutes 32 seconds. The minimum time spent on any patient in the round was two seconds - enough time for the name and destination of a well-known previously-discussed patient to be given. The maximum time was 10 minutes 11 seconds⁵. The majority of folders are presented by psychiatric registrars who also assume clinical responsibility for the bulk of cases; at the time that I was on the unit the social worker tended to see couples for relationship difficulties and clinical psychology interns took on cases of suicide attempt or parasuicide - those cases which appeared to need more psychotherapeutic-type input than the registrars had time for. Often, the folder notes had been written by the registrar on casualty duty the

previous night⁶; on occasion the clinician 'presenting' the case to the ward-round had not seen the patient.

II. PC and medical marginality

I entered PC armed with the information gleaned from the review of South African psychiatric literature presented in the first part of this dissertation. I fully expected issues of 'race' and 'culture' as they appear in this literature to be central to the functioning of PC. They were not unimportant, as will be seen later, but other factors were far more pressing. These factors led my reading in the direction of aspects of dominant psychiatric culture which may be universal, but which, at the very least, seem common to both the system I studied and aspects of the Anglo-American experience (Abbott, 1988; Caudill, 1958; Clark, 1982; Coser, 1979; Goffman, 1961; Kleinman, 1988a; Light, 1980; Rogow, 1971; Stanton & Schwartz, 1954).

The most striking thing for me as an observer of these rounds, and something about which staff spoke, was the enormous pressure under which people operated. I soon developed an acute consciousness on entering PC of how many people were 'on the bench' (waiting to be seen for the first time) or lying sedated on trolleys in the corridors. Scarcely a ward-round went by when there was not some discussion of the logistics of who would be responsible for seeing which patient, who would deal with 'the bench' and who with 'the ward', and what arrangements had been made for when registrars had to be away from the ward for other duties such as attending lectures or seeing long-term psychotherapy patients.

Adding to this pressure was the need to deal adequately with the medical side of disorder. A story often discussed while I was there was that of a patient who had been sent through as psychotic from Medical Casualty ostensibly fully checked medically. Nursing staff in PC rapidly discovered that the patient was indeed psychotic as a result of a delirium consequent on a very high fever. The patient was sent back to Medical Casualty and

subsequently died there - of medical causes. PC staff felt angry when patients who were medically ill but disruptive in some way to the smooth functioning of a medical unit were, as they put it, 'dumped to PC'. Such patients included someone who was incontinent of urine and a number of physically incapacitated old people who required medical nursing care which PC was unable to provide. Staff complained that as soon as there was any hint of psychiatric illness in a patient's history, the patient was shifted to PC, sometimes with less than adequate medical assessment.

Concern about medical conditions was important to the unit in various further ways. A substantial proportion of patients moving through PC abused alcohol or other drugs; the unit invariably had its share of patients in active alcohol withdrawal (*delirium tremens*) or who were there for 'drying out'. Medical illness of almost any kind can masquerade as psychiatric illness; one of the horrors of modern psychiatry would be the labelling, say, as schizophrenic, someone with an operable brain tumour (Lishman, 1987). Differential diagnosis between 'organic' and 'functional' conditions was seen as essential and at times vital to the patient's interests; special investigations such as blood tests, skull X-Rays and CT scans were heavily relied upon. Sometimes there would be a case of a patient with what were viewed as psychiatric problems coexisting with a medical condition; on one such occasion, tellingly, there was discussion about 'Do we try and sell her to the front?'. Clearly, 'the front' (or Medical Casualty) had far less difficulty referring 'back' to PC than the other way round; even where mistakes had been made in Medical Casualty PC staff sometimes had difficulty getting patients back into the world, or the realm (Young, 1989) of general medicine.

It is in this relationship between general medicine and psychiatry that a number of paradoxes lie, none of them clearly unique to the situation I studied (Clark, 1982), but all important. In his work exploring semiotic processes in police work, Manning (1987) has described the ways in which calls from the public for police assistance are translated into what he terms 'organisational texts' - texts which are constructed according to the rules of

the police organisation so that they can be addressed in terms of the options for action open to policemen. A primary way in which incoming calls to police are processed for example is that they are divided very early on into categories of 'serious' versus 'not serious'. In the transformation of popular texts into the professional or organisational texts of mental illness⁷, it appears that the primary organising question is that of whether the person is medically ill or not. Being medically ill as opposed to mentally or psychiatrically ill is not necessarily as stigmatised⁸, and it may allow one to return to 'the front' - the world of 'true medicine', or as dominant rationalist discourse in medicine would have it (Toulmin, 1978), the true world of medicine. Biomedicine, of which psychiatry itself is an often stigmatised or marginalised part, relies on a fundamental dualism, the precise nature of which is open to debate, but the existence of which is undisputed (Gordon, 1988; Helman, 1988; Johnson, 1985; Kirmayer, 1988; Sullivan, 1986). It is precisely in its ability to exclude from the centre of medical concerns the realms of the 'mind' as opposed to the 'body', the 'irrational' as opposed to the 'rational', the 'symptom' as opposed to the 'sign'⁹, 'illness' as opposed to 'disease', that biomedicine has been so successful in the curbing and management of disease. Although it is with the less valued parts of these pairs that psychiatry can be seen to be centrally concerned - with the 'mind', with 'irrationality', with 'symptoms' and with 'illness' - psychiatry is part of biomedicine and clinicians are acutely aware both of the spectacular success of biomedicine in dealing with what are seen as 'true' medical conditions and of the social value to patients of being 'diseased' in a tangible medical way, as opposed to being psychiatrically ill.

In this context, then, the staff of PC cannot do anything other than participate in and reproduce their own marginality and that of their patients. The identification of the medical is all-important, and this amounts to the identification of the 'real' in dominant medical discourse¹⁰. Even in cases where psychiatric illness coexists with medical illness, the primary emphasis is always on the adequate treatment not only of that which can potentially be life-threatening, but also of that which biomedicine is best at treating. This is as things should be - patients must be treated in the way the healing system knows best, but

there are important implications. The more purely 'psychological' or 'social' a patient's problem is seen to be, the more likely that it will be handled by non-medical staff (clinical psychology interns or social workers). Appropriate and necessary though this is to the management of individual cases thus referred, this system reproduces the division between 'real' work undertaken by 'real' doctors and the stuff of psychiatry which in its purest form can be handed over to non-medical and hence lower status personnel. All discussions that I witnessed during ward-rounds, furthermore, in which recent material from the psychiatric literature was mentioned or suggested for reading dealt with medical issues such as the management of detoxification of alcoholics or neuroleptic malignancy syndrome (a side-effect of antipsychotic medication). Once again, this is entirely necessary to the situation, but it represents within the psychiatric unit itself a marginalisation of the *raison d'être* of psychiatry within medicine¹¹.

It is not possible to stress strongly enough the importance of this interface with medicine for the ward-round participants, and even for those who do not take a particularly biologicistic approach to the understanding and treatment of mental illness¹². This, coupled with the fact that PC is a highly pressured and even at times dangerous place to work, severely limits what may and may not be said in ward-rounds - or, more accurately, creates an unfavourable environment for certain types of talk¹³.

III. Talk about 'race' in PC

The South African psychiatric literature, as has been seen, is concerned overwhelmingly with 'cultural' issues, and it is clear that this literature overlooks the dominant cultural factor in the PC unit - that of biomedicine. A remarkable fact about ward-round talk in PC, furthermore, is that race is very seldom mentioned. This does not mean, however, that it is not there as an issue.

A proportion of talk about race in PC can easily be implied. All patients are presented to the ward-round by name, age, gender, marital status and place of abode. The Group Areas Act of 1966 which stipulates that residential areas must be segregated by race enables one to identify people reasonably accurately by race without the category name ever having been spoken. Psychiatric hospitals segregated by race - the destination of many PC patients - also provide opportunities for covert talk about race. If one knows for example that Ms X is bound for the Orange Grove side of Eagle's Nest (the word 'white' need never be uttered), then one can be reasonably sure that Ms X is classified white. In this connection, it was only twice during my attendance at PC ward-rounds that race as a factor in placement within the hospital system was mentioned (it was discussed more frequently in connection with placement outside of this system, as I shall show later). Once it was mentioned that Spring Valley (the 'coloured' psychiatric hospital) is officially non-racial and a good placement for a white drug abuser as it has the only drug abuse unit (as opposed to alcohol and drug abuse unit) in the system. The other occasion concerned the placement of a twelve-year-old Black boy who had previously been on the Black side of Eagle's Nest and had been found in bed with other male patients. In the light of this, a decision was made to send him to Spring Valley which was described as a 'better environment' for a young boy. Some concern was however expressed for him as he was a patient who was known to wander on his previous admission and, it was said, patients are less likely to be under lock and key at Spring Valley.

It is interesting that the other time a hierarchy of desirability of services was explicitly referred to was in discussion of placement of a coloured nurse who was psychotic and 'acting out' (behaviourally disruptive). The facility best equipped to deal with psychosis and where most patients are coloured is Spring Valley. It was however decided to try to gain admission for her to Frankville (a small psychotherapeutic unit which was initially set aside for coloured patients, and remains overwhelmingly coloured). There was no explicit discussion as to why this patient should be considered for admission to a unit dealing more with personality disorders and neurosis than with psychosis, though two members of the

staff had discussed her case before the ward-round. It seemed to me implicit that the reluctance to send her to Spring Valley was related to the fact that she was a nursing sister and thus similar professionally to the staff of PC. The psychotherapeutic unit is potentially less alienating to middle-class people than is the psychiatric hospital, though racially they are the same. As always in South Africa there appears to be an intertwining between assumptions about race and those about class¹⁴.

Some other times race was explicitly mentioned in PC ward-rounds were not dissimilar to those outlined above. A Black patient, described as 'well-motivated' and 'English-speaking' was referred to a community-based organisation for care of alcoholics explicitly because, it was said, Black people 'don't fit in very well' at Adam Jones, the hospital in the psychiatric system which offers care chiefly for white alcoholics (though it is officially open to all races). On another occasion, it was mentioned that alcohol rehabilitation services¹⁵ for Blacks are 'not easily available'.

The final manner in which race was specifically mentioned in the ward-rounds I attended was in two cases, both of Black patients. In the first the patient was reported to have an atypical psychosis, possibly manic, possibly hysterical, but difficult to interpret because of the patient's Black cultural background. The second case was of a Black patient who had informed the staff that his problem was *ubuthakathi* (Xhosa for bewitched) and had said to the staff member who had taken his history that 'you don't understand what happens with us'. This case led to a discussion of whether a traditional healer should be called in. Most staff seemed in favour of this idea, but it was left to the registrar who would see the patient after the ward-round to decide on this issue. It was also mentioned that a possible plan for the patient was for him to be sent to the Black side of Eagle's Nest where more informed decisions could be made. These constituted the only two direct references to race that are clearly constructed in terms of the discourse of transcultural psychiatry.

It would be easy to interpret the relative silence about 'racial' or even 'cultural' issues in this setting as evidence of a rather sinister suppression of talk on issues of central South African concern. The silence begins to look even more alarming when one considers the widely cited local literature which suggests or at least implies that the political composition of South Africa along explicitly racial lines has psychopathogenic consequences (Dawes, 1985; Turton, 1986a; Vogelmann, 1986). Interviews I conducted with psychiatric registrars (see Part 3 of this study) would tend in some respects to support this interpretation - many of them felt unhappy about what they saw as racial discrimination in psychiatry but felt powerless to speak about it. Some even mentioned their specific discomfort at dealing with Black people in PC and having to make decisions about lives of people with whom one could not even converse, as most registrars do not speak Xhosa. A further factor which, paradoxically, could suppress discourse on race in the PC setting is that PC is located in a hospital where over recent years and after many struggles there has evolved the practice of integrating all units with respect to race¹⁶. To speak of race where the ideologically desirable position is to ignore it, is difficult.

A. The relevance (or otherwise) of race and culture to PC

Compelling and potentially useful though these lines of argument are, however, I believe that they are of little value if not considered in the framework of the issue of the position of PC as a unit within biomedical culture. There is a fundamental sense in which issues of race and culture (as the term tends to be used in transcultural psychiatry) are genuinely irrelevant to the functioning of PC rounds, and possibly to the unit as a whole. PC, as we have seen, has as a major function the best possible 'dispatch' of the patient in the shortest possible time. Even when such techniques as crisis intervention and other brief therapy methods are employed by staff, emphasis on what a registrar in an interview for Part 3 referred to as 'getting rid of the patient' (cf Mizrahi, 1984, 1987) must remain if the unit is to cope with demand. A member of PC staff referred to ward-rounds as a 'racing round-up' in which quick, uncomplicated decisions - but the best possible ones - need to be made.

Quick, uncomplicated decisions about patients demand uncomplicated views of the patients. In this context, the more one is able to reduce a patient to a medical or psychiatric 'type', the easier it is to function. As was discussed earlier, reduction to a medical 'type' may hold out more promise for the patient than reduction to a psychiatric type. Even within the context of the reduction to (or production of) a psychiatric as opposed to medical 'type', the last thing one needs to talk about in such a situation, or, indeed, can in a sense afford to think about, is the complicated question of the patient's race or culture. This being the case, it is entirely unsurprising that practically the only times race or culture are discussed are when they interfere with quick placement decisions. This interference seems to be of two major types: i) where there are no facilities for a particular patient; or ii) where the patient's mode of expression of distress falls so far out of the range of convenience of the dominant diagnostic system (the DSM III-R, APA, 1987) that the system is clearly inadequate.

Kleinman (1977), as was discussed in Chapter 1, has unflatteringly given the label 'old transcultural psychiatry' to the conventional approach within dominant biomedicine which deals with issues of culture and mental illness. This approach involves the fitting of all patients, regardless of background, to the grid of the diagnostic system of the psychiatric arm of Western biomedicine. The approach as described by Kleinman is technicist, reductionist, and universalist in orientation. Even more disparagingly, Kleinman argues that the 'old transcultural psychiatry' is a form of what he calls 'veterinary' psychiatry in which the patient's experience of symptoms of psychiatric illness is deemed tangential to the major task of fitting people to categories. These categories constitute a grid which is imposed on what the psychiatrist observes, and data are pruned to fit this grid. Barrett (1988), Harré (1985), and S. Swartz (1988, 1989) have explored ways in which psychiatric history and note-taking increasingly confine the identities which these notes construct for patients. In the case of PC, the more constrained and confined the constructed identity of the patient the better, and the more 'veterinary' and reductive the account the better. It should be noted, however, (and, indeed, it will become clear in Part3) that this reduction of

patients to entities amenable to the biomedical gaze in no way implies that staff are unaware of the limitations of what they are doing, or of the need to undo this reduction of patients at later points during their care - when the patients are no longer in a clearing-house unit¹⁷.

IV. Concluding comments

In summary, it can be said that the major cultural issues for ward-rounds in PC are not about the apparently obvious and all-encompassing questions of 'race' and 'culture' in South Africa. They have to do rather with the enabling and constraining features of the world of biomedicine and the position of psychiatry in that world. It is possible to be even more specific than this, for it is not in fact the position of 'psychiatry' as a whole in biomedicine that is at issue here, but rather the gateway to psychiatry through medicine which is crucial to the construction of patients in PC rounds. In this regard, a joke made in a PC ward-round is instructive. The clinician remarked that it is amazing how often a patient with 'behavioural disturbance' in Medical Casualty crosses the threshold into PC and becomes somebody in drug withdrawal. This is a statement about the power of medical labels in defining who patients are, but it is also a statement about the way these labels are used. In this example, it should be noted that it is the practitioners of 'real' medicine who use the vague and stigmatised language of psychiatry ('behavioural disturbance') and the psychiatrists who use the powerful, action-oriented language of general medicine (drug withdrawal). I hope that I have shown that this apparent turn-about is not as paradoxical as might at first appear. The issues at the gateway to psychiatry that is PC are the issues of the construction of biomedicine.

As I mentioned at the outset of this chapter, there is much in my report on PC ward-rounds which suggests that these are not dissimilar to ward-rounds and case conferences elsewhere in the world. I have suggested further that this could have been anticipated to some extent in view of the fact of the dominance of 'old transcultural psychiatry' (Kleinman, 1977) in

PC and elsewhere in the world. The fact that to a large extent race and 'culture' (as understood in the South African transcultural psychiatry sense) are irrelevant to the functioning of PC rounds, could be seen by some as an argument for removing discussion of such rounds from a piece of work examining aspects of culture in South African psychiatry. There are two rebuttals of this view.

Firstly, my contact with psychiatric registrars reported in Part 3 demonstrates that issues of race and 'culture' do seem central to the way registrars talk about working in PC even if these issues do not impinge forcefully on ward-round practice.

The second rebuttal is far more important than the first, and would hold even if I had not found evidence for the importance of race to registrars in their talk about PC work. There can be nothing more relevant to an understanding of the functioning of culture in South African psychiatry than an exploration of the culture of psychiatry itself. South African psychiatry is not a purely indigenous product and continues to be heavily influenced by international trends, particularly in Britain and North America. Currently fashionable attempts to make South African mental health practice more 'indigenous' (Anonymous, 1986) or 'Africanist' (Dawes, 1986) are doomed to fail if they do not explore the extent to which existing practices, and even the very terminology which is used in psychiatry and related disciplines, are determined by what may loosely be termed a 'Western' outlook. The apparent lack of emphasis on race and culture in PC is not an acultural phenomenon - it is as fundamentally cultural as would have been the emphasis I had erroneously expected.

This discussion raises the question of whether the notion of an 'indigenous South African psychiatry' is not in fact a contradiction in terms. Psychiatry as an arm of the biomedical enterprise and having a long European history (Bynum et al, 1987; Porter, 1985, 1987) cannot simply be changed into a neutral vehicle sensitive to needs of South Africans of different races. Psychiatry is not neutral, and derives much of its power from the fact that it is associated with dominant biomedical culture. My experience in PC - a unit catering

largely for people in crisis and looking, for whatever reason, to professionals for help - suggests that consideration of professional psychiatric culture is not merely pertinent to but, in fact, crucial to the development of any understanding of cultural issues in South African psychiatric practice. This may be less obvious in contexts other than PC (such as, in fact, the Black side of Eagle's Nest discussed in the next chapter), but this does not imply that it is any less important.

Notes to Chapter 6

1. As the tea room for both Medical Casualty and PC is situated just within the limits of PC's area, staff from Medical Casualty are regularly in the PC area but not necessarily in that part of the unit where patients are generally to be found.
2. At the time of writing, and approximately two years since the data for this study was collected, the accommodation for PC in the new hospital is almost ready, according to hospital authorities. The facilities are much enlarged, but the access route through Medical Casualty (the new unit) has been preserved, and I am informed by PC staff even more circuitous. This suggests that the siting of PC behind Medical Casualty can not be attributed simply to exigencies of space in an old hospital. At the very least, the pattern of citing PC at the back of Medical Casualty has been unthinkingly reproduced; it is also possible that a conscious decision was taken by hospital planners to site the new PC behind the new Medical Casualty. I unfortunately have not had access to hospital planning decision minutes.
3. I myself unfortunately did not have access to hospital statistics. Welman (personal communication) has informed me that in March-April 1988, 910 patients visited PC, some more than once. The 'diagnostic profile' was as follows:

Affective disorder (excludes major depression)	19%
Substance induced organic brain syndrome	13%
Schizophrenia	13%
Major depression	13%
Parasuicide	10%
Substance abuse	9%
Organic mental disorder (not substance induced)	5%
Other functional psychosis	3%

Although 9% of patients were given 'substance abuse' as the primary diagnosis, 35% of patients seen allegedly abused substances, and in 78% of these cases substance abuse was felt to be directly related to the presenting disorder. Alcohol accounted for 70% of the substances abused, cannabis for 13%, mixed usage for 11%, and other drugs for 6%.

By race, 58% of patients seen were white, 24% Black, and 18% coloured.

4. This can be related to the rapid increase in Black people in the area which the hospital system serves both because of urbanisation and because of scrapping of legislation making the catchment area a preferential area for coloured as opposed to Black labour.
5. It should be noted that this ward round does not constitute the only place in which discussions of patients among staff take place; staff often consult one another in offices, the tea-room, the passage, sometimes at the bedside of a sedated or otherwise not fully conscious patient, or in the nurses' station.
6. All registrars within the psychiatric system under study do after-hours work on a rotating basis. During the day, they are placed at different units in the system, remaining at each placement for six months. Psychiatric casualty is one such placement. The registrars working in PC, then, rotate with their other registrar colleagues for after hours duty. As those placed in PC by day constituted two of the nineteen registrars working in the system at the time, most after-hours duty was undertaken by registrars not working in PC by day.
7. I use the categories 'folk', 'popular' and 'professional' here in line with Kleinman's (1980) schema. I do not argue that there is a necessary and rigid distinction between these categories, but use the terms for purposes of differentiating between parts of a process whereby unusual behaviour comes to be labelled as disease. In discussing this process I do not align myself with approaches which argue that mental illness is a 'myth' (Szasz, 1961) but rather with social constructionist views which argue that the production of psychiatric texts is a matter of complex social negotiation within the framework of biomedicine (Eisenberg, 1986; Kleinman, 1988a).

Chapter 6: Psychiatric casualty ward-rounds

8. I do not wish to imply here that patients with physical or 'medical' as opposed to 'psychiatric' illness cannot be and are not stigmatised or subjected to moral scrutiny (see for example Silverman, 1987; Zola, 1981); the social stigma of psychiatric illness is however generally speaking greater.
9. I use the terms 'sign' and 'symptom' here in a standard medical way - symptoms are reports patients produce about their illness, often about pain or discomfort, and signs are indicators of disease which the medical practitioner can observe regardless of the patient's reports. Included under this rubric of signs would be bodily changes visible without the use of special equipment (but nevertheless through the lens of the medical 'gaze' - see Foucault, 1975) such as swelling and discolouration, and indicators such as raised blood pressure, and abnormalities detected through blood tests.
10. Atkinson (1988a) uses the concept of 'reproducing normal medicine' in his work on medical education. The reproduction at PC can be seen as a specific instance of this phenomenon.
11. The current revival of biological psychiatry and what has been termed the 'remedicalisation' of psychiatry could be seen to some extent undercutting my argument here. According to some influential psychiatrists, psychiatry is in the process of rediscovering its medical roots, and the true project of modern psychiatry is to discover the biology of psychiatric disease.
12. One of the registrars interviewed for Part 3 of this study and who was working in PC around the time of our interview expressed frustration at having to behave like a medical doctor when it was precisely from this role that an escape was being sought through psychiatry. The registrar in question did however confirm that this seemed to be the only way to operate in the best interests of the patients passing through PC.
13. Matthews (1980), as discussed by Wynne (1981), has described the crucial role of disposal of patients to other units - often medical - in shaping the behaviour of residents in a psychiatric emergency service. Most energy in the unit Matthews described was spent on attempting to keep the flow of patients manageable, with little else focussed on. These observations apply equally to the PC situation.
14. A further interesting fact in this regard is that it is not the policy of the hospital system to treat patients who can afford private care where such care is available and of a standard equal to that which the system can provide. Patients referred out to these facilities (which include private psychiatric clinics) were invariably white or middle-class coloured.
15. These services, regardless of the race groups for which they are designed, are not part of the system of hospitals under the aegis of the department of psychiatry concerned and are not to be confused with hospital alcohol units.
16. The issue of hospital integration by race is dealt with more fully in Part 3.
17. In their refutation of the idea that non-westerners are 'concrete thinkers', Shweder and Bourne (1982) argue that it is necessary to distinguish ideational processes from products. They suggest that it is invalid to assume that the tendency to use what have been termed 'concrete', context-dependent ascriptions in non-westerners' talk about persons is evidence that non-westerners are *unable* to think abstractly. I am suggesting here that it is important not to assume that the reductive turn of discussion in PC rounds is in any way evidence of the participants' inability or unwillingness to think in other ways. An understanding of context is crucial to an adequate appraisal of what is happening in the ward-rounds.

Chapter 7

Ward-rounds on the 'Black side' of Eagle's Nest Psychiatric Hospital

Table of contents

I.	A description of the 'Black side' and the Black side ward-rounds	147
II.	Ritualised aspects of ward-rounds	151
III.	Issues arising out of the rounds	153
	A. Multiplicity of interpretation	153
	B. The politics of interpretation	159
	C. The politics of culture	163
	1. Which culture?	163
	2. 'Culture' as a site of conflict	165
	3. 'Culture' as a source of power and resistance	168
IV.	Concluding comments	172
	A. Biomedicine, psychiatry, and the production of cultural identity	173
	Notes	176

Chapter 7

Ward-rounds on the 'Black side' of Eagle's Nest Psychiatric Hospital

I. A description of the 'Black side' and the Black side ward-rounds

The material I present here was obtained through attendance at weekly ward-rounds which for most of the period of the study were conducted in a sitting room in a locked female ward on the Black side of Eagle's Nest Hospital. When the neuroclinic on the Black side of Eagle's Nest reopened (a few months prior to the completion of my data-gathering), the rounds were relocated to an open, prefabricated building where some of the ward activities of the neuroclinic take place. The Black side of Eagle's Nest has an official bed capacity of 400. According to staff who work there however there are in fact roughly 500 beds with overcrowding and pressure on space. These figures include the forensic psychiatry unit of roughly 270 beds which has separate psychiatric staff from the rest of the Black side of the hospital and separate ward-rounds. The composition of staff at ward-rounds I attended varied according to other clinical commitments of staff, but was similar in terms of professional background to that reported for PC ward-rounds in the previous chapter.

One reaches the Black side of Eagle's Nest either through a gate on the Black side or by driving through the white side. The white side has a mixture of old and new buildings, most in a good state of repair. The new buildings, as one drives past them, give an impression of openness and airiness. There are lawns and well-tended gardens. The central administration block is old but imposing. One drives towards the Black side across a bridge which spans a highway. The first building on the Black side is the forensic unit, modern and identical architecturally to a maximum-security prison. As soon as the Black side is reached, the quality of the road surface deteriorates. The gardens are less well-kept, with large muddy areas in the rainy months. Most of the buildings are very old double storey 'asylum'-type accommodation in very poor repair - paint peeling, cracks in the walls and so

on. A cluster of prefabricated buildings appear better maintained and more cheerful. It is impossible not to notice the difference in quality of the physical environment between the two sides of the hospital¹. The rounds I attended were for the bulk of the period of my study conducted in an upstairs closed 'female'² ward in a building physically very much like the stereotype of 'the asylum' - large, very old, in need of repair and repainting and cold and dark in winter. Having opened a rickety gate into a bare garden, one walks up a cement staircase to a door which is locked. If, like me, one does not have a key, one has to shout through an opening in the door for a staff member to let one in. One walks straight into the patients' dining room, the walls of which are decorated with ward programmes, and pictures, chiefly small posters of television stars pulled out of magazines. Through another locked door one enters the ward-round room which is large and divided by a room divider with a profusion of pot-plants mainly in coffee tins. On the other side of the divider government-issue chairs and a large Victorian wooden bench are arranged around a small coffee table which has a pot-plant on it, resting on a crocheted mat. On one of the walls and, for me, dominating the room is a large poster. This poster, very colourful and drawn in the manner reminiscent of birthday cards which make joking reference to sex, depicts a bearded white man lying asleep (possibly drunk) in a hammock between two palm trees. Next to him is a table with a tankard suggesting a cocktail of the 'romantic island holiday' type (pineapple, straw, paper umbrella). In the centre of the picture seated on a small stool and at a portable typewriter is the stereotyped caricature of the Black savage. He is wearing a grass skirt and nothing else, he has thick lips and a smile which simultaneously suggests jollity, stupidity and crudity, and a bone through his hair. The caption to the poster reads, 'The only man who ever got his work done by Friday was Robinson Crusoe'. When I initially saw this poster (to me it was so striking that it was the first thing that I noticed on entering the room for the first time) I was appalled by its racist humour, particularly in a setting designed to care for Black patients. It will become clear later how other experiences modified and commented on my initial reaction. On the rest of the walls are photographs probably cut out of a calendar or advertising brochure. These depict a white young woman dressed in fashions now slightly out of date and posing with aircraft of

South African Airways, South Africa's state-run commercial airline. One of the photographs shows the woman standing on the wing of a large jet holding a beautiful cheetah on a leash. This suggested to me that the photographs might have come from a calendar promoting South Africa as a tourist destination (impressive aircraft, beautiful [white] women, safaris to the animals of Africa). Clearly, whoever had put up the pictures had been trying to beautify the room, but there is some irony in this as all the patients are Black, and very few of the social background where they would ever travel on a jet, afford high-fashion clothes, or go on safari. The fact of the matter, however, is that promotional material of this type invariably depicts economic and social realities different from those of the average Black psychiatric patient who, like most Black people in South Africa, is poor. There is an interesting addition to what I read to be the 'official' decorations of the room (attempts, I assumed by staff, to create as pleasant an atmosphere possible given the constraints of lack of funds and the building itself). One of the light fitting platens has the word 'love' scratched into it with a knife or similar instrument - one assumes by a former patient (the ward round room doubles as a patient lounge). This is the production of an inmate herself, but remains a slogan of dominant US-British culture, written in English, and reminiscent of slogans of the 1960s (coincidentally, the heyday of anti-psychiatry).

The ward-round consists generally speaking of two presentations separated by tea and cakes (provided on a roster system by staff). The purpose of the round is far less circumscribed than those I attended in PC, and, often, less clear. Patients who are to appear in the ward-round are routinely told beforehand and when they enter the room that the meeting is there so that their problems can be better understood and treatment improved. For staff, the round is known as a teaching round in which the visiting consultant and others will improve the knowledge and skills of the person presenting the case and of others listening. Some clue as to the purpose of different rounds may be found in the reasons given for the selection of particular patients for presentation, when these are in fact stated³. One class of patient presented to the meeting is that of the 'problem case' - somebody whose diagnosis is difficult to decide on, or whose treatment regime needs

further thought and discussion. Another type of patient is the 'nice case for the medical students' type - a patient who either exemplifies core symptoms of a well-known syndrome, or who has some unusual picture which may 'display' a rare disorder or one reasonably common amongst the hospital patients, but according to the professional literature rare currently or absent in Europe and the USA. This category includes phenomena falling under the broad rubric of hysteria and what some have argued to be the cognate category of 'culture-bound disorder'. A third class of patient presented is the person described simply as 'an interesting case' - interesting usually to the staff present and especially of potential interest to the visiting consultant. What defines interesting, of course, depends on the audience, and in general it is true to say that the 'interesting cases' presented to the consultant who is seen as expert in the field of transcultural psychiatry are presented as having or displaying 'cultural factors' in their condition. When the consultant was the professor whose known predilection is for universalist diagnostic systems, patients with diagnostically complex pictures were presented, even in cases where the staff looking after the patient had decided on a diagnosis. These categories for deciding on who will be presented are neither mutually exclusive nor exhaustive, but they give some idea of the range of factors affecting the decision to present⁴.

The typical format of the presentation in these rounds is i) the presenter (usually a psychiatric registrar or intern clinical psychologist) presents a detailed and highly structured account of the patient - present condition, psychiatric history, mental state examination of the patient on admission and subsequently, case formulation and diagnosis, ii) some discussion follows, iii) the patient is called into the room and is asked questions by the visiting consultant and other people present, iv) the patient is asked to leave and is further discussed.

II. Ritualised aspects of ward-rounds

Ward rounds in this context differ markedly from those I observed in PC. It should be noted that for the bulk of my time of observation they in fact existed in addition to what were known as 'working rounds' - less formal occasions in which staff members of individual wards would meet to discuss patient management. The rounds I attended were a major social event of the week for staff - people otherwise working in separate units would have a chance to meet one another and to see patients from other units. Opportunities for collegial conversation were opened up - on more than one occasion, for example, the presentation of a patient of either gender paved the way for a discussion by staff, all of whom worked in wards segregated along gender lines, of whether it was easier or more difficult to work with 'males' or 'females'. This type of discussion, which could reach the level of friendly banter, also elided into more academic-type discussion. For example, the issue of patient gender repeatedly led to a discussion of why 'hysterical' or 'culture-bound' types of presentation seemed far more common in men than in women, an observation which ran counter to many participants' intuitions, and indeed to aspects of the psychiatric literature both local and international (Foucault, 1980; Ngubane, 1977; O'Connell, 1982). The tea break provided the opportunity for staff members and students present to speak less formally in smaller groups about clinical matters. The cake in itself, however, played a pivotal role in the afternoon's proceedings. A roster was followed according to which it was decided who would bring cake in which week. On both occasions on which the person in question had forgotten to bring cake, he was hastily dispatched during the first presentation of the afternoon to the local bakery to rectify matters. The quality of the cake was always commented on, and jokes made particularly about the tendency of men to buy rather than bake cakes when it was their turn. It was often said (and I am sure this is true) that one could feed oneself entirely on cake at the hospital, by moving from ward to ward on both the Black and the white sides and attending the appropriate rounds at appropriate times and places. Cake was always served at the rounds I attended, even when for some reason

or other only one patient was presented. Clearly, to leave out a presentation of patient was acceptable, to leave out the cake was not!

Accurate though this flippant comment may be, its tone detracts from illuminating factors about the cake routine. I shall not offer a detailed defence here for the centrality of cake, though one can be made, no doubt with reference to psychoanalytic theories regarding the relationship between feeding and the giving and replenishment of emotional energy and nurturance. It is enough simply to observe that the cake routine was well entrenched and, indeed, very pleasant. Far more important than this for the present discussion however is that the presence of cake underscores an implicit function of the rounds as social gatherings and indeed as forms of entertainment. This is borne out by the description of rounds other than these as 'working' rounds. 'Non-working' rounds such as these, complete with visitors and cake, can be seen as not for working in an ordinary sense - indeed, for playing. The connotations of the word 'playing', furthermore, are not entirely pejorative, particularly when considered in a Winnicottian (1984), or even an ethogenic (Harré & Secord, 1972) light.

In a ritual sense, the partaking of food may often be associated with transformation, and the cake serves furthermore to 'frame' (Goffman, 1975) the ward-round in a particular space which may be termed, following Winnicott (1984), 'transitional'. Not only are the patients in a process of being transformed, but so, and in some respects more importantly, are those presenting and discussing the patients. Arluke (1980) has discussed what he terms 'inherent control' in the process of 'roundsmanship', control made possible by the rules which regulate the boundaries of a round. Anspach (1988), furthermore, demonstrates the role of what she terms 'the literary rhetoric of medical discourse' (p. 371) in socialising professional participants, and trainees in particular, into received medical perceptions of patients and reality. The ward-round as both a social and a theatrical event (complete with refreshments) can be viewed as an arena for the training and control not only of professional opinion but also of ways of conducting oneself socially. Who pours the

tea, how much cake is eaten, the extent to which the cake conforms to implicit rules about cake in the unit, are all features common to every round I attended.

If even the apparently trivial ceremony surrounding tea and cake can be viewed as part of the process of institutional self-regulation, how much more so can the presentation of patients be seen as integral not only to the ways patients are seen but also to the way the institution constructs itself. In discussing presentation of actual cases in the rest of this chapter, I have organised the material not case by case but under the headings of key issues, all of which speak simultaneously about the ways patients are viewed and about the ways ward-rounds reproduce and comment on institutional reality.

III. Issues arising out of the rounds

A. Multiplicity of interpretation

A case was presented of a woman who was working as a live-in domestic worker in the city in which the hospital is situated. She was socially rather isolated and appeared to be concerned for the welfare of her son who lived in a rural area some 1000km away. According to the person presenting the case, the woman admitted to the cardinal textbook features of depression. No mention was made of whether the patient remembered her dreams. The patient spoke good English and it was not necessary to use an interpreter. When the woman was called into the round, one of the white clinicians interviewed her as follows⁵

<i>Clinician:</i>	You have bad dreams.
<i>Patient:</i>	I do not have dreams.
<i>Clinician:</i>	You are troubled by your bad dreams.
<i>Patient:</i>	I do not have bad dreams.
<i>Clinician:</i>	You have bad dreams about your son.
<i>Patient (quickly, and apparently angrily):</i>	I do not have any dreams.

After this incident the clinician who had been interviewing the patient looked at others in the room and shrugged, and others began asking the patient questions. When the patient

had left the room the clinician who had put the statements about dreams to the patient asked if others had noticed how quickly the patient had denied having dreams about her son. The clinician said that this signified that the patient was indeed having such dreams⁶.

I have chosen this vignette to present first because it demonstrates many of the complexities both of what is happening in the rounds, and of interpretation. At first blush, the issues here are simple: the powerful (white) clinician is foisting a story on a resistant (Black) patient and nothing that the patient says or does will change the clinician's already made-up mind. This constitutes a coherent story, which could easily be elaborated in terms of commonly-held beliefs about the oppressive use of white psychiatry in this country against Blacks.

It is tempting to stop the analysis here: this is a story of white racism which fits the rules of talk about oppression in this country. Indeed, it is difficult to develop any other interpretation which does not lay itself open to the charge that it is simply an apologist fabrication and an attempt to construct a smokescreen for oppressive practices. I hope to show that moving beyond this analysis, on the contrary, provides a more useful approach to examining structures of power in local psychiatric settings.

A first step in trying to develop this approach lies in comparing the incident with another in a round I had attended some years previously. All the clinicians in this round, and the patient, were white. The relevant part of the ward-round for purposes of the current discussion, and as filtered by my memory, went something like this:

<i>Clinician:</i>	You were five years old when your little brother was born. Were you jealous?
<i>Patient:</i>	No, I wasn't.
<i>Clinician:</i>	Are you sure you weren't jealous?
<i>Patient:</i>	I'm sure I wasn't.
<i>Clinician:</i>	Oh, come now, you were the only child of your parents and special to them and along comes a baby to take your place and you weren't jealous? I'm sure you were.
<i>Patient:</i>	I wasn't.
<i>Clinician:</i>	I'm pretty sure you were and if you're going to deal properly with your problems you're going to have to accept it and start working on it.

One reason I remember this particular ward-round is that I felt at the time that the clinician was confronting the patient with this theory about sibling rivalry at the wrong time and place for him. Sensitivity to patients' rights to privacy and also to differ from clinicians seemed to me to be absent. More interesting than this for the present discussion however is the fact that at the time I had no doubt that the clinician's interpretation was in fact correct (if ill-timed and indelicately put). This is in marked contradistinction to my equally firm belief that the clinician's assertion that the Black patient has bad dreams about her son is incorrect.

Part of the reason for my different views on the validity of the claims made by the clinicians about the patients' emotional worlds lies in the fact that I regard the hypothesised structural factor of sibling rivalry to be of a different order from the question of whether someone has had bad dreams or not. At one level, it is simply an empirical question whether a patient has had dreams she or he can remember. The concept of 'memories of sibling rivalry' which need to be retrieved from unconsciousness if treatment is to succeed operates at an obviously more theoretically informed level. Even if this difference is important, however, a crucial factor seems to be that of the patients' being of different 'race' groups.

It is clear from consideration of these two cases and of my reactions to them, reactions very powerfully informed by my own feelings about 'race', that it may be simplistic to lay at the door of 'racism' practices which are apparently less than respectful of Black patients. Further consideration of issues possibly informing the clinician's behaviour in the first case may also prove instructive.

As the survey of the South African transcultural psychiatry literature in Part 1 showed, there seem to be key themes in that literature. Notions central to the present discussion are:

1. Black traditional healers do not ask questions as western doctors do, but present their interpretations of the situation to clients as 'the truth'.
2. Black people depend heavily on their dreams and interpretations of them for commentary and guidance on their emotional affairs.

I am not in a position to make a full assessment of the validity of the above two claims, and this is not in any case necessary to the point I am making here. It must be noted, however, that the claims had attained a particular status at ward-rounds I attended. It was not uncommon for patients to complain about being asked lots of questions in the rounds. One in fact had responded to a clinician's assertion that the ward-round was there to help her with her problems by asking, 'Then why are you all asking me lots of questions?'. She was apparently both baffled by the implicit connection between asking many questions and the provision of help, and angry at being interrogated for purposes unclear to her. The fact that patients often responded to questions in this way fitted in neatly with the view that Blacks in their 'natural' healing environments are not asked questions. The decision of the clinician in the interchange quoted above to make assertions to the patient rather than to ask questions becomes explicable in this context.

The belief that Black patients attach a great deal of importance to their dreams, similarly, related both to the transcultural psychiatric literature and to the lore of the unit. Many clinicians had been struck by the impression that their Black patients volunteer dreams for interpretation by clinicians or simply as commentaries on their feelings far more readily than do other patients. Reports of patients' dreams were not infrequent constituents of presentations in the rounds. The clinician's decision to focus on dreams clearly relates to this context as well.

Thus far in my discussion of context I have focussed on the clinician's construction of the patient as a representative of the group 'Blacks'. Clearly, this type of positional construal leaves the patient very little room to move. In particular, no space is allowed for the patient to define her identity along lines not dictated by the racial categories the clinician seems to be implying. The patient is being defined from the outside as essentially 'a Black person' regardless of whether this definition has salience for her⁷. A more fundamental fact is that the patient is being viewed as psychiatrically ill. When she asserts that she does not have dreams she is not simply breaking the rules of her constructed 'Blackness'. She is also speaking in a context of psychiatric knowledge strongly influenced by psychoanalytic theory. This knowledge asserts:

1. Things people say about themselves are not necessarily true, even if people are not consciously lying. In fact, through the use of defence mechanisms such as denial, people may say the very opposite of what is true. Nothing patients say must be taken at face value and data other than the words they use must inform any clinical formulation of patients' difficulties.
2. Dreams have meaning and hold potential for clinicians' understanding and treatment of patients.
3. One way of finding out the truth about patients is precisely through dreams - the Freudian 'royal road to the unconscious'.

The belief that things are not always as they seem (and in fact more commonly are not) forms an assumptive basis not only for local rounds but also for much of the psychiatric arm of biomedicine⁸. The mental status examination format in local use is a product of British psychiatry which in turn has roots in German phenomenological psychiatry. One of the standard items reported on in the presentation of findings of mental status examinations is that of 'insight'. Very crudely put, there is an approximately inverse relationship between

the patients' assertions regarding themselves as mentally ill and psychiatry's decision about the presence or absence of such mental illness. Patients who claim to be well psychiatrically are said to lack insight into their illnesses⁹; those on the other hand who assert that they are ill have insight and are less ill¹⁰ (cf Foucault, 1985). The clinician's rejection of the validity of what the patient was asserting, apparently on the basis of paralinguistic cues and nothing else, needs to be evaluated in the light of the tradition in psychiatry which claims that things are not always as they seem. In this context, it is not bizarre or 'racist' in any way to claim that the patient really means the opposite of what she is saying. This discussion ultimately begs the question of what, for psychiatry, it means to 'mean' anything at all. The fact that the subject matter of the interaction is that of dreams is also significant in that dreams have the dual role of being valued in psychiatry in general (or at least in that international school of psychiatry used locally) and of representing to clinicians the essence of 'Blackness'. Defensiveness about dreams especially on the part of someone who represents a group aware of the power of dreams becomes, to the clinician, understandable - even, possibly, inevitable. The royal road of dreams in this context has become doubly royal - both through the fact of dreams' being important to psychiatry and of dreams' being a royal road to the world of Black people. When this doubly royal road to the patient is found to be barred, the interpretation that what the patient says is not true becomes doubly attractive. It provides a way of positioning the patient simultaneously as Black and as a psychiatric patient. This fusion between blackness and madness has added resonance in view of the associations of both these attributes with irrationality, powerlessness and so on (Littlewood & Lipsedge, 1986)¹¹. It is possible, paradoxically, to argue that more than simply labelling the patient in a negative way the clinician by situating her at the convergence of two important discourses ('psychiatry' and 'Blackness') is giving her a privileged status of sorts.

There is a parallel here with the argument raised earlier concerning the construction of patient identities and illnesses in PC. In that context, I argued, an appreciation of the position of psychiatry in relation to biomedicine was essential. In the context of ward-

rounds on the Black side of a psychiatric hospital where 'race' cannot fail to be a central issue, an appreciation of the shaping of ideas about race by standard ideas of dominant psychiatry is as important.

B. The politics of interpretation

The fact that many clinicians, and almost all psychologists and psychiatrists, cannot speak the language of their Black patients has long been recognised as a major problem for local psychiatric practice, as was seen in Part 1 (Gillis et al, 1982; Swartz et al, 1985). Structurally, clinicians are further constrained by the fact that there are generally speaking no full-time employed interpreters in the hospital system and where such people are employed they are often so busy that it is difficult to schedule times suitable to the clinician, the interpreter, and the patient¹². A result of this is that the role of interpreter is taken on by a variety of people in different settings - patients' relatives, cleaning staff, and Xhosa-speaking clinicians¹³. In the Eagle's Nest ward-rounds, the interpreter was always one of these clinicians. There are no psychiatrists in the hospital system (indeed, in the entire region) whose home language is Xhosa, there is one Xhosa-speaking clinical psychologist in the hospital and in the entire region (a Zulu-speaking¹⁴ clinical psychologist fluent in Xhosa left the region during the course of my research), a number of Xhosa-speaking social workers, and many Xhosa-speaking psychiatric nursing sisters. This means that it is almost invariable that the person interpreting for a clinician who is interviewing a patient has lower ascribed status than that of the interviewer. The invisibility but ubiquity of one aspect of the power relationship between interviewer and interpreter can be inferred from the fact that I have not attended a single ward-round in which the interview does not begin something like this:

Interviewing clinician (to the person who will be acting as interpreter):

Please explain to the patient that this is the meeting I mentioned earlier, and these are the doctors, psychologists, social workers and nurses who will be discussing how best we can help you¹⁵.

Interpreter (to the patient, in Xhosa):
[relays the gist of this to the patient]¹⁶.

The statement made by the interviewer for interpretation to the patient is standard in all ward-rounds I have attended in which patients are called in, with some minor variations for context. A clinician who fails to make this introductory comment is considered disrespectful and rude towards patients. The statement is often followed up or accompanied by a question about whether the patient objects to being interviewed. Given the situation, rules of polite conversation and the fact that patients have generally been prepared for the ward-round appearance previously, refusals to cooperate are rare. If patients appear particularly ill-at-ease or wary, reassurances are given. These were common in the rounds under discussion here. Once these framing interchanges are over, the 'true business' of the interview of the patient can begin.

There can be no clinician who does not know these rules of the start of interviews in ward-rounds, even if these are never made explicit. They are integral to the social ritual of the round. The question then arises as to why it is that interpreters (even those who themselves sometimes take on the role of interviewer and have therefore demonstrated on occasion their ability to perform the opening statement and putting the patient at ease routine) have to be told every time to go through the ritual. To begin to answer this question we need to ask prior ones concerning the function of the opening statements in themselves. It is only partly to the patient that they are directed - they are there also as a way interviewing clinicians have of showing others that they operate according to proper rules of psychiatric conduct. They prepare patients for meetings, they negotiate with patients, they respect patients' feelings. Telling the interpreter to produce this opening ensemble of statements and questions, furthermore, may be a demonstration to other clinicians that the interviewer knows how to establish contact with patients in an acceptable way.

If the standard opening of interviews may indeed be seen as a way of establishing contact with the patient it is arguably as important in form as it is in content. From this perspective it could be argued that the interviewer as the source of potentially upsetting questions should indeed be the one to speak the standard opening words. There would be more support for this view if the talk of the interviewer were in fact addressed to the patient. In those cases where patients cannot speak English, however, this is invariably not so. Throughout these interviews it is extremely rare for the patient to be addressed by the interviewer at all, and eye contact after initial greeting is at most sporadically and often not at all maintained by the interviewer. Instead, the interviewer addresses questions to the interpreter, speaking about the patient in the third person (For example: 'Has she been having trouble sleeping?')¹⁷. In every ward-round I attended, furthermore, there was some discussion of the patient in her/his presence - usually in the form of attempts by the clinicians to clarify issues in translation, but sometimes there were more extended discussions of the patient with her/him in the room. It is probably safe to say, then, that most of the talk in the ward-round is talk *about* patients, even when patients are called in and questioned. More general implications of this fact will be discussed below; what is important here is the possibility that an instruction to an interpreter to put a patient at ease is as much a message to the interpreter and to the audience as it is to the patient.

This process of the interviewer's telling the interpreter to do what s/he already knows - clearly, an indication of the interviewer's higher status than that of the interpreter - relies for its perpetuation on the behaviour of the interpreter. If interpreters began talking to patients before being instructed to do so, they would be beginning to question or at least draw attention to the implicit rules. Far more subtle than this however is a process of simultaneous reproduction and subversion which can be seen in the consistent behaviour of one of the nursing staff, who frequently acts as interpreter. On being asked to relay to the patient the 'putting at ease' statements, she always consents to do this. On speaking to the patient in Xhosa however she always, if she has not met the patient before, introduces herself to the patient. This is of course an important way of putting a patient at ease, but

does not fit in with the explicit rules of translating and interpreting in the setting. These include: translate as closely as possible to the texts of what the two parties - the interviewer and the patient - have said; and efface yourself as far as possible from the process except when specifically asked your opinion. By introducing herself, the interpreter is making an important statement about her own position as an active contributor in the life of the ward-round; by not saying to non-Xhosa-speaking staff that she is doing this she is engaging in a form of silent resistance. The rules of the round presumably continue, but at the outset of interviews where this clinician interprets, a major factor in their simultaneous subversion has come into play.

The analysis I present here of this 'act of resistance' relies to a large extent on the same basic interpretive armamentarium as that belonging to psychiatry, and in particular on the notion of an unconscious. I am sure that if questioned as to her motives the interviewer would not at the outset view her introducing herself as a partial act of resistance. In view of this probability, it is necessary for me to present further data which could support my views on the importance of power dynamics to the interpreting situation. Such evidence can be provided through analysis of the behaviour of a Xhosa-speaking clinician who takes on both the interpreter and the interviewer roles at different times. When acting as an interviewer, this clinician always asks another member of staff to interpret. The explicit reason the clinician gives is that it is too distracting to have to act as both interpreter and as interviewer. Another reason may be that by interpreting for oneself (translating one's own Xhosa words into English) would in a sense be accounting for oneself as much as for the patient. 'Being interpreted' constitutes an important dimension of the role of the patient but is inevitably part of the role of the Xhosa-speaking clinician as well. One way to defocus from the fact that s/he is indeed being interpreted and hence associated, however tenuously, with the low status patient role is for the clinician him/herself to employ the services of an interpreter. To use an interpreter is to instruct another person in the reproduction of the rules of the situation - even if part of the job of the interpreter is to interpret one's own talk¹⁸.

Throughout the discussion in this section I have deliberately used the term 'interpretation' as opposed to 'translation' as it more adequately describes what is happening. It is, more importantly, the same term I use to refer to the construction of texts about patients' problems and identities regardless of the language they speak. It would be too easy to separate these two processes from each other by saying that one has to do with the fact that not everybody in the ward-rounds can speak Xhosa and the other with the deployment of psychiatric skills. These two processes are fundamentally intertwined. To render the patient's words into English is in part to produce a patient amenable to the scrutiny of the system within which the patient is to be treated. Interpreting the symptoms of the patient according to psychiatric schemata is in part to do the same thing. The section that follows discusses some of the templates that are crucial in developing pictures of patients in ward-round settings.

C. The politics of culture

1. Which culture?

One of the most depressing features of work in a modern psychiatric hospital anywhere in the world is that of what is known as the 'revolving door' - the phenomenon of patients' repeated readmissions to hospital (Cohen, 1988). Nobody who has worked in a hospital such as this can be unaware of stories of how this pattern has on occasion been broken - through the discovery of an underlying physical disease, through relabelling of the patient into a new diagnostic category (and hence the implementation of a new treatment regime), or through some other imaginative restructuring of treatment.

An interesting variation on the theme of relabelling within psychiatry is what I term 'cultural relabelling', well illustrated by the following example. A clinician presented to the ward-round the case of a patient who had had several admissions to hospital over the past four years, having been diagnosed variously as schizophrenic and suffering from toxic

psychosis¹⁹. The folder itself from which the clinician read notes was testimony to the type of case - it was extremely fat, to the extent that it would fall into the category of what some in the psychiatric hospital system know as a 'bible'. Previous diagnoses were read out and the clinician then with great enthusiasm reported on the findings on current admission. For the first time, it appeared, the patient had been asked in detail about dreams and also about his relationship to 'traditional' Black practices²⁰. The clinician reported that the patient was extremely concerned that aspects of his circumcision ceremony had not been conducted properly. The patient's dreams, furthermore, seemed to reveal considerable concern with witchcraft which could in turn be related to the social position of the patient's family. This reconstruction of the patient's problems in terms of 'culture' as opposed to 'psychopathology' in the narrow biomedical sense seemed to open the way for a different approach to the care of the patient. Consultation with traditional healers concerning appropriate rituals to assist the man was prescribed, and the basis was laid for more active involvement of the family in the care of the patient.

By being seen to have a 'cultural' as opposed to a purely psychiatric problem, the patient was immediately released from the potential strictures of the types of label sometimes applied by frustrated staff to the ever-returning patient. These labels include 'known schizophrenic' and 'old customer'²¹ and though not always used pejoratively do imply a necessary amount of prejudging. To relabel within dominant psychiatric discourse itself is often to release patients from the prophecy of poor outcome (as when a condition formerly seen as schizophrenia is now labelled major affective disorder), or alternatively to present poor outcome as more likely (as when adolescent turmoil is relabelled schizophrenia)²². To remove talk about the patient from the realm of psychiatry altogether is to open the door to the psychiatric unknown. Because this unknown is the unknown of culture and tradition, however, and given the value placed on these in local psychiatric writing (Swartz & Foster, 1984), the implicit message is that reuniting the patient with a collective past will make psychiatry all but redundant. Cultural rituals will be performed and these will heal

the splits both between the patient and his/her culture, and within the psyche of the patient.

There can be no doubt of the importance to patient care of knowledge of different social practices and ways of seeing the world. Emphasis on these factors in the ward-rounds I attended (and I cannot recall one ward-round in which these were not mentioned at some point) provided a useful corrective to the application of universalist psychiatry in a decontextualised way. The issue of patients' culture is however extremely complex and potentially explosive, as the analysis in the following section shows.

2. 'Culture' as a site of conflict

During the time I attended ward-rounds on the Black side of Eagle's Nest there were a number of conflicts amongst staff members and others attending ward-rounds. As many of the people concerned would be easily identifiable to potential readers, I am unable to deal with these conflicts in a great deal of detail²³, but I have tried to ensure that material I present is not too schematic. It is important to mention as well that though in many of the conflicts chief protagonists of opposing sides were white on the one hand and Black on the other, lines of conflict between some Black and some white staff were by no means consistent. On some occasions each side of an argument was represented by both Black and white people. It may be neat to assume that on issues such as these Blacks are never in conflict with Blacks and whites with whites, but this was far from the case. More often than not, furthermore, there appeared to be substantial agreement amongst participants on the final diagnoses and stories about patients.

It is interesting that it was the concept of cultural difference (essentially, between Blacks and other people) which underpinned many of the arguments. Black staff in particular resisted some white clinicians' insistence on the importance of culture, arguing that there was a danger of stereotyping along 'cultural' lines. They repeatedly pointed out ways in

which patients whose problems were being presented as 'cultural' could in fact be easily understood within conventional psychiatric theory. In the case mentioned above of the woman who said she did not dream, it was a Black staff member who somewhat angrily said to a group of people during the tea break that it was quite clear that the woman was depressed and that dreams and 'culture' had nothing to do with the issue.

At times there was even a feeling that genuine psychiatric difficulties were being forgotten as patients' problems were translated into issues having to do with Black customs and rituals. A case was presented of a man who had consulted a traditional healer for his difficulties and who had been told by this healer that he was ignoring the wishes of his ancestors. He had also been having dreams which, it was agreed by both Black and white participants, were rich in symbolism of Xhosa traditions²⁴. As discussion of the man's cultural position grew more and more animated, one Black staff member interrupted the flow by saying angrily, 'But you're all forgetting that he's a schizophrenic and is here for our help with that.'

Anger of the type expressed here was even stronger (and seldom openly expressed except to small groups over tea) in a number of other cases. These had in common the fact that the sole treatment suggested to patients in the rounds was that they leave hospital and consult traditional healers. Such advice was given generally speaking where it was felt that the patient would benefit by performing rituals either to appease ancestors who were seen as not protecting the patient from the effects of being bewitched, or to facilitate the patient's journey on the path of *thwasa* to becoming a traditional healer (see Chapter 2 for a definition). This type of suggestion would at times lead to humorous reference to the incongruity of a psychiatric hospital's making recommendations in the language of a different system of interpretation. On one occasion, a ward-round participant joked, 'Dr A (the medical superintendent of Eagle's Nest) will love this - we'll write in the patient's folder "Diagnosis - bewitched; treatment plan - dancing ritual!"' This joke operated at many levels. An important one for the purposes of the current discussion was that it

provided the opportunity for socially non-disruptive mention of the fact that using the language of culture in the way that the round had done could be seen as an abdication of clinical responsibility. Put more strongly, the joke can be read as saying at one level that the prescription of 'traditional' as opposed to psychiatric methods of treatment was a sophisticated and overtly caring way of what Mizrahi (1987) has in another context termed 'getting rid of patients'²⁵.

Conflict concerning applying cultural labels and treatment plans to patients took on a particular edge when expensive rituals were prescribed, often entailing trips to rural areas some 1000km from the region in which the hospital was situated. By far the majority of Black patients at Eagle's Nest, though not all, were, as has been mentioned, poor, many of them unemployed and living in extremely straitened circumstances often with other unemployed people. Many healing rituals would involve considerable cost, including the expense of clan members' travel to the site of the ritual, payment of the often very high fees of the traditional healer, and costs of food and beverages, some of which, like the animal to be slaughtered, constituted an essential part of such rituals. The issue of expense was raised on a number of occasions by Black staff and, once again, there would be jokes about applying to the hospital authorities for funding for such treatment (this would clearly under no circumstances be given). A white participant in rounds who was particularly enthusiastic about the potential benefits of healing rituals for psychiatric patients would say that the extended family or clan is particularly supportive in traditional African culture (an argument strongly reminiscent of many of those reviewed in Part 1 of this dissertation), and that relatives would find the money. Counter-arguments to this would generally be three-pronged:

1. It is unwise to assume that some hypothesised entity such as 'the caring extended family', even if it does exist in some - but not all - cases of Black patients, can collate large sums of money. Even if money can be collected, it may well be at the cost of

considerable hardship to a number of people already struggling (and sometimes failing) to keep themselves and their dependants clothed and fed.

2. If traditional healing were all that had been required, and had been a real possibility for the patient, the patient would not have been admitted to a psychiatric institution in the first place.
3. Efficacy of healing rituals is by no means inevitable. Many people who style themselves as traditional healers are in fact charlatans and will simply accept large sums of money without helping at all.

All these arguments can be related to the more basic criticism (which I have mentioned before) that to assume that patients, or anyone else, for that matter, can be fully defined by their embodying an hypothesised cultural essence is to engage in stereotyping. The image of the fully integrated world of the 'traditional Black person' in which the family and clan are supportive, and the healers all honest, efficacious and in tune with the nature of the Black psyche (or African personality) defocusses from viewing people in their everyday material context. 'Cultural essence' used in this way may well be seen as a weapon used against people.

The image of the notion of culture or cultural essence being used as a weapon or source of power in the rounds is important. In the next section I discuss the complexities of the concept of culture as used in power strategies by some Black people in the rounds.

3. 'Culture' as a source of power and resistance

It will be recalled that no psychiatrist and only one clinical psychologist at Eagle's Nest is Xhosa-speaking, but that there are a number of social workers and nursing staff who are native speakers of the language. This means that in general clinicians in charge of cases

are unable to converse directly with patients, and need the interpreting skills of lower-status clinicians to do their work. As has been seen, this leads to particular power dynamics when the act of interpreting between two languages takes place in ward-rounds, and, I should imagine, elsewhere as well. There are, however, more far-reaching implications of the issue, particularly as they affect interprofessional relationships.

In a psychiatric hospital which relies heavily and in many cases almost exclusively on chemical methods of treatment (and, less frequently, on electroconvulsive therapy) as does Eagle's Nest, it is clear that a considerable amount of power resides in the hands of those who control the administration of such treatments - the doctors²⁶. In the biomedical context, the power to medicate cannot but be central. This power, however, is intimately related to the power to diagnose - and at Eagle's Nest this cannot be done without the help of those who can speak the patients' language. In an important respect, then, the power relationship between nursing staff in particular and medical staff at Eagle's Nest has to be more equal than might be the cases where a common language is spoken by all. In fact, junior staff have the power to block access to patients and render senior staff impotent. On a number of occasions at Eagle's Nest rounds, particularly when there were tensions of the sort mentioned above, Black staff would engage in lengthy discussions with the patient and amongst themselves and forget (however that term may be interpreted) to translate. Such are the sensitivities to the macrosocial power issues in South Africa, however, that white staff either did not stop these discussions and ask people to translate, or they asked for such translation in an appeasing or half-joking manner.

The issues under discussion here are not simply issues of translation, however. The preemptive nature of 'cultural essence', so much a feature of South African transcultural psychiatry and of the way that a number of people at the rounds seemed to think, had an important effect on relationships on the rounds. If Black people in their 'nature' (see Swartz 1985b for a discussion of the use of this term) are seen to share a common cultural essence or African personality, then it follows that white people in talking about cultural

factors in Black patients must defer to the interior knowledge of Blackness which Black colleagues must have. It should be noted that the implications of the cultural essence position here are radical. In this view, it is not simply the case that it is more likely in a divided society that Black as opposed to white South African clinicians would have access to experiences which would make it easier for them to understand what has happened in Black patients' lives. The cultural essence view on the contrary implies that almost mystically or cosmologically all Black people share a united form of consciousness to which whites will at the very best have limited access.

The potentially racist overtones of such a view were not lost on most of the Black staff present. This was so particularly on the (rare) occasions when a white participant made explicit the view that in terms of the phylogenetic development of consciousness from the unconscious, Black people as a group were at a more unconscious level - or an earlier stage of development - than whites²⁷. Given this racism, then, it would appear self-evident that Blacks would resist cultural essence labelling in every way possible.

This was not, on close examination, uniformly the case. A noteworthy example of what appears to be a contradictory (but, as I shall argue, in another sense entirely explicable) stand to the cultural essence issue can be seen in the behaviour of one of the Black staff members. This clinician was consistently particularly vociferous and angry at perceived racism. On the occasion in question, as often occurred, a great deal of time was spent on teasing out underlying 'cultural reasons' for a patient's behaviour. Clearly irritated, the clinician in question pointed out that the patient's behaviour fitted neatly into a DSM III (APA, 1980) category. This intervention in the discussion turned the focus to more universalist psychiatric talk, and mention of 'cultural background' was not made again. After some time, the same clinician and with more apparent irritation and anger than before, said, 'But you people (i.e. whites) cannot possibly and will never understand what it is like for this person as a Black person.' On being asked to elaborate, the clinician replied,

'I don't just mean in terms of what our houses are like or the fact of poverty; I mean that there is something central about being Black that white people will never know.'

At first blush, this apparent about-face may be read simply as an inconsistency on the part of a person angry about many things, and determined to maintain an offensive style regardless of logic. A second interpretation may relate to the position of the clinician as a Black person. Black clinicians of biomedicine, and particularly in psychiatry, may be seen to be practitioners in a field which rejects what has been termed 'traditional medicine' and sees it as outmoded and 'unscientific'. Some such people may wish to reject any hint that 'traditional medicine' is appropriate to Black people as there is an association with the stigma of backwardness. At the same time, however, they may genuinely believe in and experience a sense of otherness from non-Black people. A third reading of the clinician's behaviour could be more personal and relate to ambivalences within the clinician's family about rejection of 'traditional Black values' and the pursuance of a career in 'Western' psychiatry. A fourth interpretation could be that the clinician is shifting between two discourses, both associated with struggles for liberation in South Africa but in an important respect incompatible. The first of these discourses is that of non-racialism and the second that of black consciousness which stresses pride in a black essence. This black essence, though, is highly valued and never associated with 'backwardness'.

Any or more than one of these readings may be correct, but for the purposes of the current discussion the most salient reading is somewhat different. It is clear that the clinician concerned rejects the racist overtones of South African 'cultural relativism', and strives to point out similarities between people. At the same time however, within the context of the hospital system, the clinician enjoys considerable power precisely by virtue of being associated with the very 'cultural essence' s/he seeks to reject. To be consistent in the argument that Black people are basically the same as whites implies, simultaneously, the relinquishing of important power. This power cannot be gained through professional status (medical personnel always top the hierarchy) or through being Black in a country which so

clearly discriminates against Blacks. What is necessary, then, for the maintenance of power, is for the clinician willy-nilly to 'be' a Black person in a particular way - a way, paradoxically, which this same clinician at another level completely rejects.

Looked at in this way, to be the bearer of Black culture in this context is to hold a double-edged sword. Even if the clinician concerned is aware of this (and I suspect this to be the case) it is by no means easy to lay down that sword. The benefits at this stage seem to outweigh the personal costs. This observation is not intended to suggest a necessarily conscious strategy on the part of this clinician or others. It does go some way to show, however, that it is by no means only 'racist' or 'white' people who have an investment in maintaining the image of a neatly culturally divided universe. It also helps explain one dimension of how a much disliked aspect of ward-rounds in Eagle's Nest may in part be being subtly reinforced and perpetuated by at least some of those people who most dislike this aspect²⁸. Quite how what may be termed this 'structural ambivalence' may impinge on the care of patients, is not entirely clear to me. It would be interesting in later research to explore in some detail differences between staff interactions with patients who subscribe to the view that as Blacks they are essentially different from whites, and with patients who see themselves in more universalist terms.

IV. Concluding comments

It has not been my concern in this chapter to assess in any of the cases discussed which of the stories, 'psychiatric' or 'cultural', was the more correct. It is however informative to note the extent to which the arguments in Eagle's Nest Black side rounds centred around decisions about choice of one story above another. This observation reinforces the view that the issue of cultural relativism is indeed crucial in the construction of South African transcultural psychiatry both as a theoretical discipline and in its realisation in clinical practice. The mere fact of ward-round arguments apparently forcing participants to choose between two 'worlds' for the location of distress, furthermore, regardless of what these

worlds are, echoes the well-established dualisms of biomedicine - including that between mind and body (cf. Scheper-Hughes & Lock, 1987). This observation returns us to an examination of the place of psychiatry in medicine. The rest of this chapter will draw conclusions from both the data presented here and from that presented in the previous one.

A. Biomedicine, psychiatry, and the production of cultural identity

People who become severely emotionally disturbed²⁹ have a chance of entering psychiatric care. Many patients who enter psychiatric hospitals in the system under study, particularly during some crisis, do so through the PC unit. This unit is reached through the door of biomedicine, through the physical examination and the special investigation. A major route to psychiatry, then, is through a process of observing the body as separable from the mind, of the consideration of disease as opposed to illness, of the stripping away of the veneer of the 'cultural' so that the empirical reality of the medical can be examined.

Should the problem prove 'unreal' in the sense in which physical reality is the only reality, the patient moves into the clearing house of PC where unreality, like reality before it, has to be systematised and categorised. In PC, the experiences 'mad' people have had which have not lent themselves to translation into medical symptoms can now be further categorised into psychiatric symptoms. These symptoms represent the freezing of emotional experience in such a way that it can be dealt with through routing of patients into broad categories of similarity.

With an ever-reduced psychiatric text written about them, most Black patients who are hospitalised go to the Black side of a large psychiatric hospital - Eagle's Nest. In this environment they are further away from the dominant eye of general biomedicine than they were in PC and are also at the point where treatment must begin to replace diagnosis.

For patients to gain entry into the psychiatric realm through that of general biomedicine it was necessary for individual characteristics to be glossed over and for patients to be fitted to a crude grid. This grid is constructed partly through the diagnostic system in use and partly through the exigencies of sites of treatment available in the hospital system. Once patients have been duly routed, say, to the Black side of Eagle's Nest, clinicians must begin to develop stories about them which do not lead simply to diagnostic and routing decisions. Possibilities for change need to be developed; the question of who any given patient may become is now important. The cultural identity of the patient, to some extent irrelevant to and even inimical to the initial contact with medicine and psychiatry, needs to be reinvented. The aspect of medicalisation so necessary in our society for the reformulation of social factors into symptoms has to be reversed. The cultural identity thus produced for purposes of talk about patients resonates with the assumptions about culture, and in this case, about 'Black culture' that clinicians hold. Given the fact that the psychiatric enterprise, like any other social practice, is embedded in the matrix of relationships of the society in which it operates, the struggles, overt and covert, of that world realise themselves in psychiatric talk.

I hope that I have indicated in this part of the dissertation that the practice of psychiatry relies simultaneously and at different points in its operating sphere on the attempt to efface and the attempt to create social identities - indeed, as a discourse on identity. Because of this, psychiatry offers an excellent opportunity for an examination of the production of those identities. If psychiatry is in its nature politically conservative, as has so often been argued (Ingleby, 1981a, 1981b; Miller & Rose, 1986), then part of the reason for this may lie in the fact that to some extent it can control the number of texts available for the production of identities in those it observes. Clinicians in psychiatry when producing identities for their discussions of patients and hence for their treatment of patients cannot but rely on the social texts which resonate with their own assumptions about the world. Where these texts are different there is likely to be conflict between clinicians, but all of these texts, no matter which clinicians produce them, are elaborated within the necessarily

self-maintaining psychiatric world. In South Africa, a major factor in that world seems to be the positions clinicians take with respect to the construction of cultural difference. Further exploration of these positions and how they are spoken of by some clinicians will be considered in Part 3.

Notes to Chapter 7

1. Since the data for this chapter were gathered, a large renovation project has commenced on the Black side, which should improve matters. There are however no new units comparable with those on the white side being built.
2. Although the ward houses only women patients, men patients from other wards would also be presented at these rounds.
3. It should be noted that relative to numbers of patients in the wards at any time, the two who appear at ward-rounds of this type constitute a very small proportion.
4. There are of course also far more mundane factors operating here, such as which registrar or clinical psychology intern 'needs practice in presenting' or simply whose turn it is seen as being to present next. The pressure to produce an 'interesting' or complex case however is so strong that on more than one occasion consultant psychiatric staff apologised for there being a dearth of such cases. Twice an apology was made for there being no 'cultural' cases on the wards at the time of the round.
5. I must stress that the recordings I have made in rounds are very hastily written, and direct speech as reported here cannot be taken to be a completely faithful depiction of the exact words used.
6. I make no claim here that the interpretation made by this clinician was shared by all others present.
7. This form of construing of course predates the interchange under discussion here - the psychiatric system has implicitly decided through its placement of her that the categories of 'Black' and 'woman', for example are relevant to her. For a discussion of broader issues in the politics of the production of identity in South Africa, see Du Preez (1979). The issue of the social function of categories is dealt with by Lakoff (1987).
8. I shall argue in Part 3 that belief in the unconscious plays an important role in the control of psychiatric registrars' behaviour.
9. Exceptions of course are those patients regarded by psychiatry as indeed well - generally, people who have responded well to treatment or who have been inappropriately placed in psychiatric care.
10. The point that I am making here can easily be misinterpreted as a crude anti-psychiatry argument. I am not trying to suggest that psychiatrists live in a professional Alice-in-Wonderland world in which words can be made to mean anything. Part of the power of psychiatry does however lie in the fact that clinicians in this system are invested with the right to determine and alter without notice the rules by which talk will be judged. Criteria, explicit or otherwise, for assessing the validity of clinicians' application of such rules do exist. The psychiatric and particularly the psychodynamic literature is replete with examples of discussion about 'correct' and 'incorrect' interpretations both with respect to timing and with respect to the way these are used in the clinical setting. Patients called into ward-rounds, however, usually do not have access to these criteria. Such patients may even, at times, be told by clinicians wishing to reassure them that there are no rules, and no right or wrong answers. True though this may be in one sense it is false in another as the quality of answers may have bearing on the way the patient is treated. This myth of there being no right or wrong answers may be related to what Light (1980) has termed the 'myth of structureless socialization' in professional psychiatric training.
11. In this regard, it is also probably not irrelevant that the patient is a woman.
12. Registrars who spoke to me about their work in PC (Part 3 of this dissertation) said that arranging for an interpreter to come to assist them at PC was practically impossible, in spite of the fact that interpreters have recently been employed at De Hoop.
13. Xhosa is the language spoken by the majority of Black people in the region.

Chapter 7: Ward-rounds on the 'Black side'

14. Zulu and Xhosa are cognate languages and fluency in one implies the ability to understand the other.
15. Another version of this is that when the person doing the interviewing is a visiting consultant and has not before met the patient. In this situation the interviewer may or may not introduce him/herself by name, but will say much the same thing, checking with the clinician responsible for the patient's care that the patient had been prepared for the round.
16. My own command of Xhosa is unfortunately not good enough for me to follow accurately exactly what is being said.
17. This can become amusing when one of the standard psychiatric questions about schizophrenia is asked. The interviewer in this situation asks the interpreter to ask the patient whether s/he has been hearing voices speaking about her/him in the third person. This of course is precisely what has been happening in the ward-round. In a situation such as this it is imperative that it be conveyed to the patient that the conversations which are of interest to psychiatry are those the patient may hear when nobody else is present.
18. The dynamics of interpretation and the blurring of roles between interpreter and interviewer are of course far more complex than I have space to explore here. One very interesting area for comment, for example, is that of where the patient in fact speaks or at least understands English but is still interpreted for. Another interesting phenomenon is that of the Xhosa-speaking clinician who conducts a lengthy discussion with the patient without interpreting. In my experience this situation makes clinicians very uneasy, and it is very difficult for non-Xhosa-speakers to intervene to ask for interpretation. This underlines the fact that power in the ward-round can be located in a number of apparently contradictory places - among them the power to order another person to translate the patient's words, but on the other hand the power to be sole conduit through which talk from the patient and talk from the clinician can flow. I discuss this in more detail later in the chapter.
19. The local salience of the term 'toxic psychosis' is discussed further in Part 3. It is sufficient to note here that the term is used to denote a psychosis presumably caused by cannabis and/or methaqualone abuse.
20. For a discussion of the construction of 'tradition', see Spiegel and Boonzaier (1988).
21. Both these terms were used in PC ward-rounds while I was there.
22. The issue of the negative effects of certain psychiatric labels was mentioned to me by a number of the registrars interviewed for Part 3.
23. The issue of confidentiality raises its head again in Part 3, where, in fact, it has a more constraining effect on the interpretation of data than in the present discussion. It could be argued that I am too concerned about the issue, but I believe that this is not the case. The people who attended rounds accepted my presence in good faith and were consistently courteous and helpful towards me. Others within the same department (and, paradoxically, only people whose work I did not observe and whom I did not interview) have expressed suspicion about my intentions and could potentially react in a negative way to some of my arguments. I am satisfied that my work has the potential to be constructive rather than otherwise, and am prepared to stand by it. Making public identifying details of debates in the rounds, however, could embarrass a number of the participants and also, potentially, jeopardise the chances of future researchers to continue with similar work.
24. The patient had dreams about white cows, crossing a river to meet ancestors, and about participating in various healing rituals all of which have been associated in the literature with what has been termed 'Xhosa traditions' (Bühmann, 1987).
25. It is unfortunate for the purposes of the present discussion that I did not follow up the decisions made in the rounds to see whether they were carried out (I did not, in fact, have permission to do this). Informal discussions with staff, however, suggest that it was extremely rare for any patient to be

Chapter 7: Ward-rounds on the 'Black side'

referred to a traditional healer without a commitment to close follow-up and monitoring on the part of the hospital. If this impression reflects reality, there are many possible interpretations, not mutually exclusive. These include arguments centering around institutional resistance to admitting that patients can possibly be better treated in other systems; concern for the well-being of the patient and desire not to slough off responsibility; and lack of genuine confidence in the efficacy of 'traditional' healing methods being prescribed.

26. As in many situations of this kind, of course, it is usually up to nursing staff to administer drugs and observe reactions, and nursing staff often play a major role in having regimens changed or abandoned and even in questioning the competence of more junior medical staff in particular (see, for example, Light, 1980). The picture is not as clear-cut as might be assumed.
27. This view can be related to a particular interpretation of the work of Neumann (1954) whose work falls into what Dalal (1988) would view as a racist Jungian tradition. The question of whether the interpretation is accurate raises many issues about such work and these are not germane to the present discussion. I must point out however that this type of comment was excruciatingly embarrassing to both me and to almost all other white people present. Part of the effect of this embarrassment however was that such statements were never challenged as the subject was always immediately changed.
28. This entire argument, of course, has parallels with the ways in which other oppressed groups participate in and perpetuate their own oppression. Some women for example are in the position of holding on to what is narrowly defined as woman's role in patriarchal society because it provides for them the only sense of power they know.
29. My terminology here is of course highly psychiatrised in itself. This seems appropriate to the current discussion, but it should be pointed out that I do not view terms such as 'emotionally disturbed' to be separable from the context in which they have been created.

PART 3

INTERVIEWS WITH PSYCHIATRIC REGISTRARS

Chapter	Title	Page
8	Introduction	180
9	Registrars' reports on patients from different backgrounds	222
10	Registrars' talk about psychiatric services, culture, and race	257
11	Registrars' ranking of vignettes	286
12	Professional issues in registrar training and their relationship to questions of race	306

Chapter 8

Introduction to Part 3:

Interviews with psychiatric registrars

Table of contents

I.	Broad aims	182
II.	The focus on psychiatric registrars	184
	A. Why practitioners of the discipline of psychiatry?	184
	B. Why psychiatric registrars?	185
III.	Theoretical background	188
	A. Paradigmatic tensions in psychology and cross-cultural psychiatry	188
	1. 'Old' and 'new' paradigms in psychology	188
	a) An important methodological rider of the 'new' paradigm	191
	b) An important theoretical feature of the 'new' paradigm	193
	2. New paradigms in medical anthropology and cross-cultural psychiatry: some parallels with new paradigms in psychology	195
	B. Organisational ethnography and the study of professionalism	196
IV.	Method	197
	A. The registrars	197
	B. Procedure	198
	1. Interview 1	199
	2. Interview 2	200

Chapter 8: Introduction to interviews with registrars

C.	Materials: the vignettes	205
1.	The vignette of Mr A	210
2.	The vignette of Mr M	211
3.	The vignette of Mr X	212
4.	The choice of suburb names	213
D.	Data analysis and presentation of results and discussion	214
	Notes	216

Chapter 8

Introduction to Part 3:

Interviews with psychiatric registrars

I. Broad aims

This part of the dissertation deals with the results of interviews I conducted with psychiatric registrars in the system I studied. The specific aims and construction of the interviews are spelled out in more detail later, but by way of introduction it is necessary to mention that the motivation to conduct these interviews centred around the following questions:

1. Does the way that clinicians responsible for the bulk of psychiatric care in the hospital system under study talk about 'race and 'culture' shed further light on the themes that emerge from the current South African literature on transcultural psychiatry (Part 1 of this dissertation) and from the observations that I have made concerning issues of 'culture' and 'race' in aspects of clinical practice (Part 2)? Looking for information of this kind provides further opportunities for data triangulation (Fielding & Fielding, 1986) and multiple perspectives on the same question.
2. Do these clinicians believe that discrimination on the basis of race exists in their services, and that they play a role in perpetuating it? How do they talk about issues such as racism in South African psychiatry?
3. Given that these clinicians are part of a university which has a long liberal tradition, vehemently opposes discrimination, and has committed itself repeatedly to desegregation and working towards a post-apartheid democratic South Africa¹, how

do clinicians justify their being implicated in discriminatory practices, should they indeed see themselves as so implicated?

4. Are there factors in the structure of psychiatry and psychiatric training as realised in South Africa which may shed light on the questions raised above? In other words, does an examination of aspects of clinicians' reported experience of psychiatric culture itself help provide a framework for understanding how clinicians say they deal with 'culture' as understood in the narrow South African sense (as discussed in Part 1)?

These questions are clearly very broad indeed and needed to be narrowed both from a conceptual point of view and so that manageable data could be collected. My first step was to choose a specific population of clinicians on which to focus. My observations at ward-rounds (Part 3) enabled me to gain some perspective on the relationships between different professions and the impact of these on issues of race and culture in the psychiatric system under examination. My experience of these ward-rounds confirmed my earlier impressions as a trainee and teacher, as well as research impressions (Miller & Swartz, in press), that interprofessional relationships are an important object of study, but extremely complex and fraught with political and personal tensions. My study does not have these relationships as a central focus. Given that I had already explored aspects of them willy-nilly in my research on ward-rounds, I wished to gain a perspective on the issues outlined above from the point of view of members of one important discipline in the psychiatric field. Before I turn to a discussion of the theoretical underpinnings of this part of the study, I shall explain my decision to focus on psychiatric registrars (residents) as this decision has implications for the ways in which I use theory as a basis for framing the study.

II. The focus on psychiatric registrars

A. Why practitioners of the discipline of psychiatry?

My decision to focus on practitioners of the discipline of psychiatry itself (as opposed, say, to psychiatric nursing, psychiatric social work, occupational therapy or clinical psychology, all of which could provide information with its own particular richness, and all of which form an integral part of modern psychiatric practice) may seem self-explanatory. It is however in need of defence if I am to avoid a simplistic equation between psychiatrists and the far broader social institution of psychiatry. This equation is potentially disrespectful to psychiatrists in that in a voluntarist way it implicitly makes psychiatrists themselves solely responsible for the institution of psychiatry (and hence for all its ills)². It is also potentially disrespectful to members of other, less powerful disciplines in the psychiatric field, in that it may ignore the role these play in the construction of psychiatry, and in its successes³. Psychiatry itself was chosen for the following reasons:

1. In South Africa, as in many other parts of the world, only psychiatrists take ultimate legal responsibility for patient care in psychiatric institutions. Whatever the *de facto* situation may be in particular wards or units, psychiatrists are officially in charge. In the system under examination it is extremely rare for any person other than a psychiatrist to carry responsibility for a unit⁴.
2. Psychiatric training (four years) is longer than the clinical training in psychiatric units undertaken by other staff. Only psychiatrists, once qualified, will have had substantial clinical experience (of at least six months) in all of the subspecialties in the psychiatric system, such as child psychiatry, geriatric psychiatry, forensic psychiatry, alcohol and drug abuse treatment, psychiatric casualty work, wards for psychotic patients, and psychotherapeutic units. Speaking to a range of people within the discipline of psychiatry itself, therefore, would increase my chances of tapping responses based on experiences in the full range of psychiatric units.

3. In the system under study, as in others (Light, 1980), it is the individual consultation which is ascribed highest status in the care of patients, in spite of the fact that the bulk of patients' time is not spent in such individual consultations. Although such consultations are officially conducted by clinical psychologists and social workers and less commonly (and, often, less formally) by nurses in the system, most consultations are undertaken by psychiatrists or psychiatrists in training. It is on the basis of such consultations that case histories are written up and presented at ward-rounds, and treatment planned.
4. The responses of persons within the discipline of psychiatry itself would be less likely to be coloured by dissatisfaction about interprofessional power relationships than those from others. I would be less likely therefore to be faced with a situation in which it was unclear how much of my data could be attributed to respondents' concerns with interprofessional issues⁵.

B. Why psychiatric registrars?

Having decided on practitioners of psychiatry as my focus, I was faced with the question of which psychiatrists and/or trainee psychiatrists to interview. It would not be possible or profitable for me to interview all psychiatrists, qualified and in training, in the system under discussion, as numbers were too great for the time I had available. I had decided at the start of the entire project that at no point would I sacrifice quality of data for breadth of scope. The project, in any event, is broad in its conception, and I wanted to be certain that the data I did collect were of good quality (I deal more with this issue later). The most obvious subgroup among the psychiatrists and trainee psychiatrists was that of the trainees - the psychiatric registrars - and I decided to interview them, for the following reasons:

1. As is common in other systems of medical and psychiatric training (Light, 1980), registrars assume the bulk of the case-load in all of the units in the system. One's

chances as a patient arriving at Psychiatric Casualty or any other unit in the system are overwhelmingly that one's case will be managed by a registrar as opposed to a qualified psychiatrist or member of any other professional group⁶.

2. Once qualified, psychiatrists are placed in charge of (or, at least in a supervisory position in) specific units, and may lose familiarity with the range of patients in the system⁷. It is possible, for example, for a psychiatrist to have worked almost exclusively with white, neurotic, patients for the past ten years. The opinions of such a person on, say, the presentation of psychotic Black patients to Psychiatric Casualty may be interesting, but would not be based on fresh clinical experience. Some qualified psychiatrists, furthermore, are in administrative positions with no direct clinical responsibility for any ward or unit.
3. Qualified psychiatrists responding to my questions could have interests in presenting the system in which they work in particular ways. In some important cases (particularly those where the psychiatrists in question had published material on race and psychiatry in South Africa or held office in professional psychiatric organisations) the opinions I would receive would be likely to be close to formally drawn-up policy. This information is important but was accessible to me through other channels (the literature I examined in Part 1), and I was more concerned here with material essential to the everyday functioning of the system but not codified - the 'folk knowledge' of the organisation. Implicit rules of an organisation, furthermore, are often more accessible to persons entering the organisation or training in it rather than those who have lived in it for some time (Garfinkel, 1967).
4. Qualified psychiatrists could potentially have more reservations about answering my questions openly than could trainees, because of the possibility that their responses could reflect organisational difficulties. The fact that my method included the use of vignette exercises (as I describe below) could also engender some unease

amongst qualified psychiatrists. These exercises were not designed as tests of professional knowledge, but could potentially be read as such. Previous experience in the system lead me to believe that a number of psychiatrists would be unwilling to participate in the study, and that the pattern of refusal would lead to a skewed picture in the results⁸.

5. Previous researchers had identified trainees as important foci for study because of their status in the organisation as those who receive the wisdom, formal and otherwise, from persons more experienced. As participants in a rite of passage, registrars would be likely to be highly attuned to value messages in the system (Mahdi et al, 1987; Turner, 1987). In his anthropological studies of psychiatric residents in the USA, Gaines (1979) was able to demonstrate the interaction between folk knowledge and professional models in their conceptions of disorder. From a sociological perspective, both Coser (1979) and Light (1980) identify the ambiguities experienced by psychiatric residents as crucial to their development and a rich source of information.

The chief arguments against studying registrars as opposed to qualified psychiatrists are probably that because registrars were in training, their opinions on the issues I was interested in exploring would be: i) unlikely to be crystallised; ii) incompletely articulated in terms of an overview perspective of psychiatry; and iii) potentially unstable in that opinions could change rapidly within a training environment. The longitudinal perspective of studies such as those of Coser (1979) and Light (1980) bears out the argument that registrar opinion is probably fluid and at times inconsistent. It is also likely however that the perspectives held by permanent members of staff would fluctuate. It is furthermore the very fluidity of incompletely articulated ideas with which registrars work every day that impinges directly on the lives of patients. Finding unstable, incompletely justified opinions in this study, therefore, would constitute a strength as opposed to a weakness, and, once

again, the study as a whole has made provision for the examination of relatively clearly articulated views (Part 1)⁹.

A problem remaining within the confines of this study is that fact that in the absence of longitudinal data on registrars' changing responses over time it is difficult to know exactly how and in what directions registrars' views may change¹⁰. To some extent, this problem is addressed by the fact that the registrars I interviewed were all at different stages of training, which would allow for examining the possibility of there being 'stage-specific' responses to my questions¹¹. A longitudinal design in the current South African context of rapid social change, furthermore, would introduce the possibility of data far too unwieldy for the limited aims of this portion of my study. Local historical events likely to occur within the two years, say, after my first interviewing the registrars are likely to imply far more social upheaval and change in social arrangements than those in the USA at the time of the studies by Coser (1979) and Light (1980) - not that events in the USA at those times were unimportant historically. These local events and their relationship to clinical practice would require detailed study in themselves.

In sum, the choice of psychiatric residents for interview respondents would enable me to talk to people clinically responsible for the bulk of patient care in the system. The views of registrars had good potential to illustrate implicit and previously unexpressed features of local psychiatric practice and their relationship to questions of race and culture.

III. Theoretical background

A. Paradigmatic tensions in psychology and cross-cultural psychiatry

1. 'Old' and 'new' paradigms in psychology

In introducing a recent text on the analysis of ordinary explanation (Antaki, 1988a), Antaki (1988b) distinguishes between two traditions of research on social explanation. I reproduce his table schematising these differences below:

Features of research on social explanation in two traditions

	Research on explanations held mentally	Research on explanations exchanged publicly
Types of explanation	<i>Causality emphasized</i>	Definition emphasized
Questions addressed	<i>Accuracy and bias Information processing Effects on behaviour</i>	Intention Mutual knowledge Social regulation Rhetoric
Types of theory	<i>Social cognitive (e.g. attribution theory, schema theory)</i>	Pragmatics Ethnomethodology Discourse analysis Symbolic interaction
Methods used	<i>Laboratory studies Rating scales Questionnaires</i>	Interviews Documents Linguistic corpora
Data	<i>Individuals' responses on controlled dimensions</i>	Discourse

(Reproduced from Antaki, 1988b, p. 6).

Antaki distinguishes between the two approaches outlined in the table in the following way:

On the one hand the theorist sees the explanation as a representation of what the individual thinks, or, if no commitment is made to the thought being an articulate one, to what is stored in the individual's cognitive warehouse. On the other hand the theorist sees the explanation existing in the space between the explainer and the audience.
(Antaki, 1988b p.6).

Recalling more general debates in the social sciences and in psychology in particular¹², Antaki (1988b) criticises the mentalist approach to the understanding of explanation. He argues that this approach holds a limited view of causation, and constructs a model of everyday explanations which assumes that such explanations mirror the form of experimental psychologists' research methods. An important reason for Antaki's (1988b) preference for what he terms 'research on explanations exchanged publicly' is that work in

this tradition does not assume that it is possible to anticipate the structure of explanations in advance of their being elicited. More particularly, this second approach does not rely heavily on notions of linear cause in what Harré (1970) has termed the Humean tradition. In the tradition with which Antaki is aligned, then, (developed from Harré and Secord's, 1972 'new paradigm' in social psychology) it cannot be assumed that explanations in particular and accounts or talk in general will necessarily conform to a given structure. From a methodological perspective, the paradigm requires that data be collected in as 'raw' a form as possible, and certainly not *a priori* by means of questionnaires and structured psychometric instruments.

In the absence of a uniform structure of responses in all research, however, the task of the researcher becomes more difficult. 'Old paradigm' or what has been termed 'positivist' research addresses its questions in such a way that responses are easily codable and fit the requirements of pre-arranged templates, often statistical¹³. The 'new paradigm' aims to describe structure in a mass of qualitative data or discourse in such a way that one is certain that such a structure has presented itself from within the data and not from the imposition of the researcher's own framework. This is clearly an unattainable ideal. The 'new paradigm' itself is the first to point out that in looking at data any researcher cannot but construct his/her own picture of the material - a picture informed by the assumptions of the researcher.

The methodological challenge of allowing the data to impose their own structure, and the problem of reflexivity (to which I alluded in my introduction to Part 2) have been addressed in a number of ways. A burgeoning literature on qualitative research methods in the social sciences has suggested a number of techniques for the codification of qualitative data, for 'discovering' structures in data, and for assessing reliability and validity (Kirk & Miller, 1985; Miles & Huberman, 1984). Other researchers have suggested that structuring of data in accordance with an articulated social theory enables the researchers to claim not that they have discovered 'the truth' about their data but that they have indeed organised

their material according to specific rules which are in themselves open to scrutiny (Harré, 1988; Manning, 1987)¹⁴. This approach in particular lays the way open to a reassessment of the validity of the assertion that there is a rigid distinction between quantitative and qualitative research. Regardless of the ways in which material is collected (whether by controlled laboratory experiment at one extreme or by naturalistic observation of behaviour in the social environment at the other), the researcher is inevitably involved in a process of constructing a system by which to interpret that material - creating a reality, or a story of some kind about the material (Clifford & Marcus, 1986; M. Gergen, 1988). This being the case, the methodological issue becomes not so much a choice between 'qualitative' and 'quantitative' methods or 'discourse' versus 'questionnaire' techniques as can somewhat simplistically be implied from Antaki's (1988b) table reproduced above, but rather that of the place of a range of techniques in an overall structure of interpretation (Stainback & Stainback, 1984). Multiple methods, furthermore, can play a role not only providing in complementary data, but possibly more importantly in allowing for the possibility of tensions between types of information obtained through different techniques (Fielding & Fielding, 1986). These tensions or inconsistencies, far from presenting the researcher with a problem which must be overcome in the search for 'old paradigm'-type 'truth', are to be embraced and welcomed in 'new paradigm' research in that they foreground the role of data-gathering itself in the construction of knowledge.

The 'new paradigm' approach has an important methodological rider and an even more important theoretical underpinning, each of which will be discussed in turn.

a) An important methodological rider of the 'new' paradigm

As we have seen, the 'new paradigm' does not require the rejection of quantitative and statistical techniques in favour of exclusively less structured approaches. What is essential, however, is that the quantitative approaches not be allowed to determine from the start the way that data is collected, and, indeed, key aspects in the relationship between the

researcher and respondents. Research beginning with tightly structured questionnaires, for example, immediately conveys to the respondent that the researcher has a working structure which could not possibly have been negotiated with the respondent him/herself as it is presented as a *fait accompli*. This implies that research techniques (and, indeed, the research relationship) should begin, as far as possible, at the least structured pole of the continuum but can move to more structured methods. This can be undertaken only once it is clear that each level of greater structure takes a form which does not violate the respondent's own way of constructing reality. An archetypal research process in accord with this methodological principle could then be schematised as follows:

naturalistic observation

participant observation/observing participancy

unstructured interview of key informants

structured interview of key informants

questionnaire

psychometric assessment

As one moves down the hierarchy, data collection methods become more and more specific and screen out more and more information. Ideally, though, each step to further structure should be a product of what has transpired between the researcher and the researched at previous levels. In practice, of course, there can be few studies which could actually go through all of these stages. Nevertheless, a comparison between two texts dealing with ordinary explanations of behaviour illustrates the value of the hierarchical approach as a principle. Furnham (1988), in a book on lay explanations (including lay explanations of psychiatry), presents material gleaned from a variety of respondents to a variety of questions. Interesting and valuable though some of the information obtained may be, what is striking about it is that regardless of the topic under discussion (psychiatry, medicine, economics, etc.) responses all seem to be organised in the same way - according to the dictates of the statistical reworking of questionnaire responses through techniques such as

factor analysis. A brief article by Antaki (1989), by contrast, on students' explanations of political protest, is mindful of the issue of not imposing structure inappropriately or fitting data to a predetermined template. Antaki's (1989) study is small and does not go through the stages of the hierarchy I have outlined above. Because Antaki collects his data in as unstructured a form as he is able given the practical constraints of the study, however, he is able to generate (with judicious use of statistics) a picture of structures of explanation which does not mimic patterns seen in countless studies on a range of topics. In this respect, it differs from all of those of Furnham (1988). Antaki's (1989) contribution to the literature, then, because of the way that the research was organised, is able to provide information about structures of explanation. This information could have been lost had he decided to collect the data through uncritical reproduction of 'old paradigm' methods. In the current study, I have attempted to open myself to the potential benefits of methodological advances of the 'new paradigm' not by avoiding 'old paradigm' techniques altogether but by locating these in a research structure moving from observational data (reported in Part 2) to very loosely structured interview data to more highly structured data based on a standard exercise conducted in an interview setting (to be reported on in Part 3).

b) An important theoretical feature of the 'new' paradigm

In locating its data in social relationships and intercourse, 'new paradigm' psychology abandons the model of the researcher trying to discover the truth about his/her passive subject, and instead emphasises the extent to which information is constructed by the participation of both researcher and researched. It is for this reason that Antaki (1988b) labels the 'new paradigm' approach to the study of explanations '*Research on explanations exchanged publicly*' (see the table reproduced above). Instead of focussing on data as evidence of mental or cognitive structures, Antaki (1988b) emphasises that we should explore social processes in the everyday construction of meaning, and, indeed, of reality. This emphasis on social processes as opposed to cognitive products can be seen to be an important feature of the social constructionism movement as espoused most centrally by

the work of K. Gergen (K. Gergen, 1982), which has parallels with the constructionist approach to medical knowledge (Wright & Treacher, 1982). Recent work on the emotions has also emphasised the socially constructed nature of even what in Western culture is often assumed to be the private world of the emotions (Harré, 1986; Heelas & Lock, 1981).

This tendency in the 'new paradigm', was anticipated theoretically by an emphasis in new paradigm philosophy of science (notably, the 'realist' approach of Harré, 1970) not on the cognitive products of science but on science as a social and personal process. For Harré, the philosophical study of science has in the past been too concerned with how established scientific theories can be modelled as cognitive products. This approach tends to overlook the non-cognitive, social, emotional, and even serendipitous factors which go into the making of any scientific theory¹⁵. For Harré, the study of science becomes part of the study of any social process. Distinctions between methods for examining 'scientific' and 'non-scientific' behaviour become blurred (Gilbert & Mulkay, 1984).

The implications of this for the study of any scientific or professional enterprise (however those words may be defined) are considerable. Scientific or professional explanations are 'social facts' in the same way as popular explanations are¹⁶. Similarly, it becomes possible to study the social theories of ordinary people not as less developed or corrupted forms of 'true scientific explanation' but rather as evidence of the attempts of all people (scientists and professionals included) to make sense of their world (Draper, 1988; Harré & Secord, 1972, Kelly, 1955). When studying the way that professional people or scientists, therefore, talk about the objects of their work or study, it becomes possible to examine this talk in the same way that one studies 'ordinary' talk or explanation. The ability of 'new paradigm' psychology to study science in the same way that ordinary explanation is studied has important parallels in recent developments in anthropology, and, more particularly for purposes of this dissertation, in medical anthropology and cross-cultural psychiatry, as will be seen below.

2. New paradigms in medical anthropology and cross-cultural psychiatry: some parallels with new paradigms in psychology

Kleinman's (1977) 'new cross-cultural psychiatry' as discussed earlier in this dissertation has many similarities with 'new paradigm' psychology. It is not irrelevant that the article which Kleinman (1977) used as a basis for his attack on the 'old transcultural psychiatry' was in fact written from a psychology department and in the tradition of 'old paradigm psychology' (Singer, 1975). Like Harré and others in the field of psychology, Kleinman and colleagues within medical anthropology have been concerned to develop a hermeneutic approach to science, which respects the integrity of qualitative data and rejects what Good and Good (1982, p. 141) have termed the 'empiricist theory of language' (Good, 1977; Good & Good, 1980, 1981, 1982; Good & Good, 1988; Good et al, 1988; Kleinman, 1977, 1978, 1980, 1987, 1988a, 1988b; Kleinman et al, 1978; Kleinman & Good, 1985).

Even more noteworthy for purposes of the current discussion is the fact that the 'new cross-cultural psychiatry' recognises as fundamental the cultural construction of psychiatric categories and diagnostic systems (Kleinman, 1983, 1988a; Lock, 1987), and, once again, opens the way for discussion of professional discourse in the same way that popular discourse is examined (Swartz, 1987a). Recent texts in the field of medical anthropology and cultural psychiatry have increasingly begun to focus on the cultural construction of 'Western' medicine and psychiatry themselves (Hahn & Gaines, 1985; Lock & Gordon, 1988). The terms 'social construction' and 'cultural constructivism' have become currency in the psychiatry and medical anthropology literature (Eisenberg, 1988; Gaines, in press; Lock & Gordon, 1988). In keeping with more general trends within anthropology as a whole (Clifford & Marcus, 1986), medical anthropology has become increasingly concerned with the construction of facets of 'Western' or 'dominant' culture - including the construction of its professional disciplines¹⁷. It is no mistake that Littlewood's (in press) recent review of ten years of the 'new cross-cultural psychiatry' is entitled '*From categories to contexts*', as the context of *all* practices has become a crucial focus.

B. Organisational ethnography and the study of professionalism

The material to be discussed in this part of the dissertation was collected together with that in the previous two parts and under the same general aim of exploring aspects of culture and the understanding thereof in areas of South African psychiatric practice. As such, the data is informed by the general organisational ethnographic approach (Jones et al, 1988) which has a long and illustrious history in the study of psychiatry (Caudill, 1958; Coser, 1979; Goffman, 1961; Light, 1980; Stanton & Schwartz, 1954). Many of these texts focus as well on patterns of professional socialisation, as do other studies of careers of psychiatrists and other health professionals, and of professionalism itself (Abbott, 1988; Allen, 1988a, 1988b; Groopman, 1987; Louw, in press; Merton, Reader, & Kendall, 1954; Murray, 1986; Sparr et al, 1988).

The studies mentioned above are important to this part of my dissertation in that they deal with issues of defining and understanding the contexts in which registrars work and patients from a variety of backgrounds are treated. My study has a different focus from any of those mentioned above, however, in that I am concerned primarily with how practitioners talk about and make sense of very specific issues, notably, those of race and culture, within a circumscribed context. I hope to show in the final chapter of this part of the dissertation in particular that examination of the broader context of local psychiatric training is essential as a framework for understanding responses adequately. One approach to this type of question is a cognitive psychological stance of the sort adopted by Schwartz and Griffin (1986) in their study of medical thinking. In keeping with my commitment to the tenets of 'new paradigm' research as outlined above, however, I have chosen not to explore hypothesised mental models. Psychiatric registrars' accounts on certain issues will be explored as social and cultural facts.

IV. Method

A. The registrars

At the time of my study, there were nineteen psychiatric registrars in the system under study. Their modal age was in the 30-40 year age group with a few being slightly younger (in their late twenties) and some in their early- to mid- forties. None had completed any other medical specialty, but their range of previous experience varied somewhat. Most had had medical experience beyond the mandatory single year of practice post-internship, and two had left medicine for a time to pursue other interests but then returned.

All but one of the registrars agreed to participate in my study, yielding a group of eighteen who took part. I do not have the permission of the single registrar who refused to take part to reveal the reasons for his refusal, but I am able to say that this registrar was demographically similar to most others (white, male, 30-40 age group). I have no reason to believe that the responses of this registrar would have appreciably affected the overall pattern of results. The reasons for this registrar's refusal, on my reading of them, do not have bearing on the research questions.

Of the eighteen registrars studied, sixteen were men and two were women. Two of the registrars (one of them a woman) were classified coloured, the remainder white. All bar one of the registrars spoke English at home; one of the white males was Afrikaans-speaking but had for many years conducted studies and professional activities in English and was fluent in the language. The registrars' pattern of training in psychiatry up to the point of interview is described in Appendix B.

A number of registrars, though willing to take part in the study, were very concerned about issues of confidentiality, given their status as trainees. Because of this, and because of the fact that my research has engendered some media interest and controversy in the Department of Psychiatry under examination, I have made the difficult decision to obscure

all aspects of respondents' identities at all times. Demographic groups which may be of particular interest as far as the data are concerned (e.g. coloured registrars, women, Afrikaners) are all far too small to allow any discussion which would not reveal identities of particular respondents to those who know them and the system concerned. All this potentially interesting information is therefore effaced from the discussion that follows. It will also be noted that though I present the patterns of registrars' previous placements in Appendix B, I do not link these with the consistent labels I give the registrars later in the dissertation, because it is possible to divine each registrar's identity from his/her particular placement pattern.

Erikson (1968) mentions the unfortunate irony that often in studies of identity the very factors which are crucial to a respondent's identity - the 'identifying data' such as the person's name, place where s/he lives, age and so on - are omitted for reasons of confidentiality. I have no doubt that my argument at certain specific points has been weakened or made less easy to follow by my decision not to reveal the identities of particular respondents¹⁸. In a study of this nature, personal factors play an important part in the responses obtained. Ethical considerations must however override others, and I am convinced that what I am at liberty to reveal has value in itself.

B. Procedure

All registrars were contacted in the first instance by means of a form letter, a copy of the text of which appears in Appendix C. I then telephoned each registrar, and set up an appointment at the registrar's convenience for the first of two interviews. Subsequent interviews were arranged either at the conclusion of the first interview, or by telephone later. All eighteen participating registrars took part in both interviews, and all interviews were audiotaped with registrars' permission.

1. Interview 1

These interviews were very loosely structured - I had some core areas which I made sure were covered in each interview, but I allowed the registrars' own interests to determine much of the form of the discussion. This combination of core areas to be covered in all interviews and loose structure had the potential to provide me with information from which I could generalise about the group and with information about more idiosyncratic aspects of the registrars' talk about themselves and their work. The loose structure on initial contact with registrars, furthermore, accords with the methodological principles I have outlined earlier.

Interviews lasted between 45 minutes and two hours, with a mode at around an hour. With registrars' permission, as has been mentioned, the interviews were tape recorded. On two occasions recording equipment broke down during the interview and I took detailed notes. Core areas covered in the interviews were:

1. registrars' training and experience after leaving school; reasons for deciding to do psychiatry; placements on the registrar rotation until the date of interview; their own professional socialisation from non-psychiatrist to psychiatrist.
2. views on the relationship between psychiatry and general medicine
3. views on the relationship between psychiatry and power
4. views on psychiatric work with Black and coloured patients
5. politics, racism and psychiatry in South Africa

Prior to beginning my study as a whole I had thought that I would probably be asking questions about all these areas with the possible exception of the second. My experience in ward-rounds in psychiatric casualty (as discussed in Part 2) convinced me that this was in fact a key area which I needed to cover.

My purposes in interviewing the registrars at such length were multiple. I wanted to establish as good as possible a rapport with them for purposes of the vignette study (to be described later), and informal conversation about themselves and their work seemed to be one way of establishing this. I was also interested in their views on the areas I have outlined above, both for purposes of this dissertation, and for baseline information for a follow-up study in some years' time. I have an interest in issues of professionalism and professional socialisation in particular both in psychology (L. Swartz, 1986b, 1988) and in psychiatry. Follow-up studies would enable me to explore ways in which people change over time. This is of special interest in the South African context of rapid social change, violence and upheaval¹⁹.

It is clear, therefore, that the data I gathered during the interviews were not all for the purpose of the current study. Later in this chapter I discuss my approach to deciding on which aspects to report in this dissertation.

2. Interview 2

This interview was far more structured, and was designed, as will be seen, to elicit specific responses concerning questions of race and culture in South African psychiatry and in the system under investigation in particular. In each case, the registrar was handed a sealed envelope containing a sheet of three vignettes (the construction of the vignettes themselves is discussed below). The registrar was asked to read the first vignette to him/herself, and was then asked a standard series of questions about the vignette. The procedure was repeated for each of the other two vignettes. Finally, the registrar was asked to rank the

three cases according to certain criteria. The exercise with each registrar took between 45 and 75 minutes, and responses were tape-recorded.

This part of the study lent itself, more than any other part of my work for this dissertation, to the gleaning of data on a standard response sheet. I could have sent the vignettes to registrars with forms to fill out and have simply asked them to post completed forms back to me. I decided against this procedure for a variety of reasons.

1. Particularly as the registrar population is relatively small, I wanted to maximise my chances of receiving responses from all respondents. Registrars are under considerable time pressure in their daily work, and a proportion of them, quite understandably, would probably simply not have taken the time to fill in and return forms. A further relevant fact was that a few weeks prior to this part of my data-gathering another psychologist had sent forms to registrars and other personnel asking them to note down some very personal information. No direct contact had been made with the respondents in this study to explain what would happen to the information if they chose to write it down. A number of registrars informed me that they had simply thrown the questionnaires away, and that they felt intruded upon and angry. It was in my interests to behave in a way which made my dissociation from the other study clear.
2. It was important to me to structure the responses I received as little as possible, and to allow for data to be gathered the form of which I had not anticipated. By collecting the information in an interview format I could glean both relatively 'hard' data (in the form of specific responses) and the quality of registrars' discourse on a variety of topics.
3. My presence enabled me to prompt registrars when I could not understand them clearly, or when they seemed to me to have more to say or were hesitant. This

would be likely to be particularly true in cases where registrars were tending to treat the exercise like an examination with right and wrong answers, the effects of which perception I wished to obviate as far as possible.

4. My presence enabled registrars to give me feedback on the task itself and to inform me of their impressions about what I was trying to glean through the exercise. It also, and very importantly, allowed me to assure registrars that they were under no obligation to answer all the questions and to ask that they tell me if they found questions meaningless, obscure, badly conceived or phrased. A danger with paper-and-pencil information is that respondents may write responses simply for the sake of filling in all the blank spaces on the page. In such a case, it is difficult for the person reading the responses to interpret how seriously the questions were taken.
5. Although I could not control for this completely, I wanted to maximise the probability that registrars would not communicate with one another about the task and thus potentially influence one another's responses. If they had received the vignettes by post in their common room the chances of their discussing them casually with one another would probably have been greater than after individual interviews arranged at different times and places convenient to them. At each interview I was also able to make a personal appeal to each registrar not to discuss with colleagues or anyone else anything of what had transpired. At the end of the interview, furthermore, I took back the vignette set that the registrar had been reading, so I can be certain that none of these was in circulation.

A major disadvantage of the interview method is that it allowed for responses to be presented in idiosyncratic and potentially difficult to compare forms. It is further possible that my saying to registrars that they were not obliged to answer all questions could have led to more refusals to answer items than had these words been embedded in a long letter of explanation accompanying a form to be filled out. A more serious potential problem

than these, however, was the possibility that by my presence I would influence the responses in some way. Paper-and-pencil responses are not immune to influences of this type, however, and these influences are very hard to detect from reading a form. My having constructed the vignettes did mean that I would probably respond in a more encouraging manner to some of what the registrars told me than to other aspects. I did try to some extent to minimise this influence by being blind to the particular vignettes and vignette order registrars would receive (details of this are presented below), but by the end of every interview I had divined what the vignettes were. This does represent a difficult-to-control drawback in my data collection method, but was a necessary price to pay for the other benefits.

I did consider using a research assistant who did not necessarily hold my assumptions and emotional investment in the data, but decided against this for a number of reasons including that of finances. I had reason to believe that my status both as a clinical psychologist and as someone known within the hospital system would improve my access to registrars and their willingness to talk to me. To employ someone with the same status would be expensive and potentially open to many of the same problems inherent in my own collecting of the data. Regardless of whom I would employ, furthermore, such a procedure would add the variable of the research assistant's assumptions and style to the picture. It would by no means remove the factor of registrars' responses' being moulded both by their perceptions of me as the researcher and by their experience of their relationship with whoever was conducting the interviews (an assistant or me).

The questions asked of the registrars were as follows²⁰:

In the case of each vignette

1. What is the most likely diagnosis or set of diagnoses you would consider for this person?

2. What is the likely aetiology of the condition?
3. If you were to make up a story about this man, what other information (in terms of history, presentation, or anything else at all) would you think likely to be true of him?
4. What sort of care or treatment plan would he receive? (Registrars were prompted to speak of all stages of treatment both in-patient and follow-up if they did not volunteer the information)
5. How would you estimate prognosis in this case?
6. What, if any, would be the particular problems in dealing with this patient?

Ranking questions

Please rank the three cases you've read according to the following criteria

1. From the one about which you are most certain of the diagnosis to the one about which you are least certain of diagnosis
2. From the one who will receive the best psychiatric care overall to the one who will receive the worst
3. From the one with the best prognosis to the one with the worst
4. From the one you personally would most enjoy working with as a clinician, to the one you'd least like to work with

5. From the one you would personally be the most effective with as a clinician, to the one you'd be least effective with.

All registrars were also asked to comment on the exercise and to add anything they felt relevant.

C. Materials: the vignettes

Three vignettes were prepared. Each registrar was given each of the three vignettes for assessment, but the names of three suburbs (Arderne, Lumko and Myrdale) were attached to the vignettes in different combinations. Each registrar read one vignette as dealing with a patient living in Arderne, one dealing with a Lumko patient, and one dealing with a Myrdale patient. Suburb names were assigned to vignettes subject to the constraint that six registrars would read a vignette about Mr A from Arderne, six about Mr A from Lumko, and six about Mr A from Myrdale, with the same breakdown by suburb for the vignettes of Mr M and Mr X. The actual vignettes and reasons for choice of suburbs will be described later. It is sufficient to mention here that it was anticipated that vignettes dealing with a person from Arderne would be likely to be read as being about coloured people, those from Lumko would be read as being about Blacks, and those from Myrdale about whites²¹.

Subject to the constraint that each registrar should respond to each of the vignettes and to each of the suburb conditions, six different sets of three vignettes each were generated, randomised with respect to order of presentation²². Each set of vignettes was randomly assigned a number (1-18). A colleague, similarly, randomly assigned numbers from 1 to 18 to the registrars' names, and placed each vignette set in an envelope marked with the name of the correspondingly numbered registrar. The number of the vignette set and that of the registrar did not appear on the vignette set or on the envelope, and the envelopes were sealed until each registrar opened his/her envelope to read at the data-gathering interview. This meant that I did not know in advance which registrars would be receiving which match

of vignette to suburb and in which order, and I was given the list of registrar numbers for analysis purposes only after all the data had been collected. For purposes of maintaining respondent anonymity I refer to the registrars throughout this dissertation by the numbers assigned to them in this process (i.e as Dr 1 to Dr 18). The registrars' numbers are consistent throughout so that readers can identify whether a series of remarks quoted at different points in the dissertation come from the same registrar. I list below the registrar numbers, and the vignettes they received, in the order they received them:

Dr 1:
Mr M from Lumko
Mr A from Myrdale
Mr X from Arderne

Dr 2:
Mr M from Myrdale
Mr X from Lumko
Mr A from Arderne

Dr 3:
Mr X from Myrdale
Mr M from Arderne
Mr A from Lumko

Dr 4:
Mr M from Arderne
Mr A from Myrdale
Mr X from Lumko

Dr 5:
Mr A from Arderne
Mr M from Lumko
Mr X from Myrdale

Dr 6:
Mr A from Lumko
Mr X from Arderne
Mr M from Myrdale

Dr 7:
Mr X from Arderne
Mr M from Lumko
Mr A from Myrdale

Dr 8:
Mr X from Lumko
Mr A from Arderne
Mr M from Myrdale

Dr 9:
Mr X from Myrdale
Mr A from Lumko
Mr M from Arderne

Dr 10:
Mr X from Lumko
Mr A from Myrdale
Mr M from Arderne

Dr 11:
Mr A from Arderne
Mr X from Myrdale
Mr M from Lumko

Dr 12:
Mr M from Myrdale
Mr X from Arderne
Mr A from Lumko

Dr 13:
Mr A from Myrdale
Mr X from Arderne
Mr M from Lumko

Dr 14:
Mr M from Myrdale
Mr X from Lumko
Mr A from Arderne

Dr 15:
Mr M from Arderne
Mr X from Myrdale
Mr A from Lumko

Dr 16:
Mr X from Lumko
Mr M from Arderne
Mr A from Myrdale

Dr 17:
Mr X from Myrdale
Mr M from Lumko
Mr A from Arderne

Dr 18:
Mr X from Arderne
Mr A from Lumko
Mr M from Myrdale

Common criteria governed the construction of all vignettes:

1. All were to be *short* so that they could be read and responded to quickly. Brevity is also advantageous in that it allows for more free speculation about the case on the registrar's part.
2. All were required to be *diagnostically complex* so that in no case would there be an obvious right or wrong answer, and so that registrars should have ample room within the confines of the vignette to speculate and project.
3. All were required to be cases in which the question of *admission as an in-patient* would probably come up, which would help ensure that registrars would talk about a broad range of facilities without feeling that such discussion was irrelevant to the case at hand.
4. Vignettes were standardised by *age* and *gender*. As far as possible I did not wish talk about race and diagnostic category to be further complicated by these issues.

The choice of age was relatively easy to make: the late adolescent/young adult age group represents the modal one in which major psychiatric disorders tend to begin (DSM III, 1980; Kaplan & Sadock, 1988), and I wanted to choose an age definitely within the adult age group so that speculation about 'adolescent turmoil' would be minimised, and another variable excluded²³. As it is not uncommon for Black people still to be scholars in their early twenties (for a variety of reasons including starting school late and repeating years because of school boycotts) I chose the age of 25 which placed the cases firmly within the young adult, non-schoolgoing category.

My decision to opt for identifying the vignette characters as uniformly male was less easy. The vast literature on gender and psychopathology reveals important cultural

preoccupations about the relationship between femininity and madness (Chodoff, 1982, Littlewood & Lipsedge, 1986). For some time I have been interested in connections between ways in which women are viewed and presented and the presentation of madness (Swartz, 1982, 1985c, 1987a). In the South African context specifically a number of authors have raised questions about the relationship between the social position of Black women and manifestations both of hysteria and of culturally accepted possession states, as was discussed in Chapter 2 (Ngubane, 1977; O'Connell, 1980, 1982). My own clinical experience, an example of which I have discussed in Chapter 4 (the case of Ms A), has also led me to view the issue of female socialisation as an important factor in the cultural construction of psychiatric disorder. This view was apparently corroborated by the discussions about gender by staff members in ward-rounds as mentioned in Chapter 7. In the end, it was precisely the richness of material possible to be gained from the simultaneous discussion of the 'otherness' of Blacks and the 'otherness' of women (all but two of the registrars are male; all but two of the registrars are white and the remaining two coloured²⁴) which convinced me that for the current study it was preferable to designate the patients in the vignettes male. Male status in addition gave me the opportunity to explore the 'cultural category' of 'toxic psychosis' (see below), a condition which holds an interesting place in local psychiatric culture, and which is commonly seen as a 'male' condition.

5. Vignettes should as far as possible be *credible* in the context in which registrars work and particularly in the psychiatric casualty unit. To this end, although I constructed the vignettes largely with the aid of symptom definitions of the Present State Examination (Wing et al, 1974 - I discuss this procedure below), I based the stories on common themes that emerged during my attendance at ward-rounds in Psychiatric Casualty (as discussed in Chapter 6). I tried to construct the stories in such a way that they would mimic referral notes commonly received by the

registrars, and even included specific mention of the Medical Casualty unit associated with Psychiatric Casualty.

6. Each vignette should contain information which could facilitate talk about '*cultural issues*' in psychiatry. How this was achieved is discussed below.

The vignettes, as a group of three, were chosen such that they should have different but potentially overlapping clinical pictures. I wanted to be sure that the pictures were unlikely to be read as different stories about the same person at the same point in the illness. On the other hand, I also wanted to avoid absolute clarity of diagnostic differentiation between the pictures, for reasons similar to those described above under point 2. No diagnostic labels were used in the vignettes, therefore. This led to the additional benefit of registrars' not being influenced by pejorative or other connotations of particular labels (Gallop et al, 1989).

The technical details of the construction of the vignettes according to Present State Examination (Wing et al, 1974) syndromes are presented in Appendix C. On the advice of the Head of the Department of Psychiatry at the time I checked the vignettes against DSM III (APA, 1980) criteria as well to make sure that my intentions to highlight aspects of particular diagnostic areas were fulfilled in the light of the diagnostic system officially at use in the Department at that time.

The choice of basing the vignettes on the Present State Examination, ninth edition (Wing et al, 1974), was made for two overlapping reasons:

1. The instrument (the 'PSE') represents the crystallisation of many of the strengths of British empirical psychiatry. It describes symptoms in great detail and specifies rules by which these are seen to relate to each other. Having been used in various versions in a range of international studies, including the International Pilot Study of

Schizophrenia (WHO, 1973) and in South Africa (Gillis et al, 1982; Swartz et al, 1985), the PSE can be described as the apotheosis of a particular form of dominant universalist psychiatry. Basing my vignettes on this instrument (particularly with the back-up of the equally powerful DSM III) enables me to say with some confidence that I have indeed constructed vignettes which conform to a dominant model of psychiatry likely to be familiar to registrars taught in a system very much influenced by British psychiatry.

2. The PSE and the general approach to research and to diagnosis that it embodies and implies was greatly valued in the Department of Psychiatry. A number of senior members of the department had received specialised training in the instrument, conducted research using it, and taught according to its structure. The vignettes, then, were likely to be couched in a manner to which registrars would have ready access²⁵.

Each vignette will now be discussed in turn.

1. The vignette of Mr A

The case of Mr A reads as follows

Mr A is a twenty-five year old man living in [suburb]. He is admitted to [Psychiatric Casualty]²⁶ with the following symptoms, as reported by his family. For the past two weeks he has been 'in a funny mood'. He has appeared very happy, saying that he's full of exciting ideas, but he has also been accusing people of wanting to poison him and of being able to read his thoughts. When questioned about what has been happening to him he has claimed that there is witchcraft going on and he may be being hypnotised but he is not sure by whom. On admission to [Psychiatric Casualty] he is fidgety, restless and paces up and down, and when questioned is unable to say where he is.

This case was constructed directly from the syndrome profile reported by Rottanburg (1982) in her dissertation on psychosis following cannabis abuse. This dissertation, a portion of which was adapted for publication as an article in *The Lancet* (Rottanburg et al,

1982), represents a central preoccupation of the Department of Psychiatry, as will be discussed below. The vignette has the advantage of containing apparent elements of manic disorder, paranoid features and Schneiderian first-rank symptoms of schizophrenia, and apparent disorientation, allowing for a range of possible responses.

2. The vignette of Mr M

The case of Mr M reads as follows

Mr M is a twenty-five year old man living in [suburb]. He is admitted to [Psychiatric Casualty] complaining that he has trouble thinking clearly. He says that he cannot make decisions about even the smallest task, no matter how hard he tries. When asked why this is happening to him, he says that it may be that he is troubled by thoughts which are not his own. He is concerned that he may have committed a crime but also entertains the possibility that a spirit has entered his body and may be responsible for his actions. His family reports that he does not sleep at night and has lost weight. There seems to have been a change in him over the past few weeks as he always used to follow serials on the radio but has not put the radio on during this time, claiming that he is not interested.

This vignette is also diagnostically complex, with the major decisions concerning a choice between a schizophreniform psychosis and a major affective disorder, depressed type. A number of symptoms are deliberately expressed ambiguously - for example, it is not clear whether the change from being an active radio listener to not listening at all is a result of lack of interest consequent on depression, or a product of delusions of reference regarding radio broadcasts (a schizophrenic symptom). If the strict rules of the CATEGO program of the Present State Examination (Wing et al, 1974) were adhered to, a schizophrenia diagnosis would be generated (as in fact is the case with all the vignettes) because CATEGO follows the Fouldsian hierarchy of assigning more diagnostic weight to schizophrenic symptoms than to symptoms of affective disorder. In the CATEGO system, then, a patient with only a single 'nuclear syndrome' symptom (this syndrome corresponds to Schneiderian symptoms of first rank) and symptoms from the four depressive syndromes (simple depression, depressive delusions and hallucinations, special features of depression, other symptoms of depression) can receive a tentative diagnosis of schizophrenia. The DSM III (APA, 1980) would not operate in exactly this way. The vignette was designed to

prompt registrars into talk about depression as a syndrome and depressive symptoms occurring in other conditions. Depression is a key issue in 'transcultural' psychiatry internationally (Kleinman & Good, 1985; Littlewood & Lipsedge 1989) and locally, as has been seen in Chapter 2. I was keen to see, for example, whether Mr M from Lumko (i.e. a Black Mr M) would be diagnosed depressed less often than a Mr M from elsewhere - a finding which would be in keeping with the history of the evolutionist study of depression amongst blacks.

3. The vignette of Mr X

The case of Mr X reads as follows

Mr X is a twenty-five year old man living in [suburb]. He is referred to [Psychiatric Casualty] from [Medical Casualty] with the complaint that he is difficult to examine physically as he seems very uncooperative. When asked to stand up, for example, he sits down, and vice versa. [Medical Casualty] has not been given any reason for his admission and he appears physically healthy. When asked by the registrar on duty to describe what has been happening to him he says this is not necessary as the registrar can read his mind. He looks rather puzzled and seems to be preoccupied with something but is evasive, though he admits that he feels he can carry on conversations with spirits, whom he can see.

This vignette offers the opportunity for talk about 'atypical psychosis' (the 'Schizophrenia O' syndrome of the Present State Examination) and about negativism associated with catatonia. A possible interpretation of this picture falls within the realm of 'brief reactive psychosis/ hysterical psychosis/ hysterical pseudoschizophrenia, to name a few terms that have been used (Gift et al, 1985; Hirsch & Hollender, 1969; Hollender & Hirsch, 1964). It also raises the possibility of discussion of 'culture-bound syndromes', particularly as the dissociative features of the last sentence are commonly seen to be typical of possession states (Ngubane, 1977; Simons & Hughes 1985).

4. The choice of suburb names

In South Africa, the Group Areas Act of 1950, as mentioned in the discussion of ward-rounds in Psychiatric Casualty (Chapter 6), requires that people live in areas defined for their own 'race group'. Identifying vignettes by suburb rather than explicitly by race enabled me to be reasonably sure that registrars would read off the implied race without my having to mention it. Direct mention of race could focus their attention on race unnecessarily and therefore load responses too much. Presentations in Psychiatric Casualty, furthermore, routinely cite suburb and omit direct reference to race, as was seen in Chapter 6, and I wanted the vignettes to be as similar in form to everyday referral notes as possible.

The areas of Arderne (coloured), Lumko (Black) and Myrdale (white) were chosen because they are all mixed areas economically, having residents ranging from very wealthy to poor, though of course it is true that the usual pattern of wealth according to race in South Africa does apply here too. Myrdale over all is a richer area than Arderne and Arderne richer than Lumko. The suburbs are in close proximity to one another and all near to Eagle's Nest and De Hoop Hospitals, and all equally far from Spring Valley Hospital (which caters mainly for coloured people). The areas are all reasonably well-established, none of them, for example, being predominantly a squatter community housing a large proportion recent arrivals to Cape Town, or a suburb created almost for the sole purpose of rehousing people moved out of other areas under the dictates of the Group Areas Act. I suspected that migration and urbanisation might be factors alluded to by registrars. I did not wish to affect the probability of this occurring, for example, by designating as my 'Black' area a squatter settlement where many people have recently come to Cape Town. Such settlements are commonly (and erroneously) thought of by many whites as providing shelter exclusively for recent migrants.

D. Data analysis and presentation of results and discussion

A total of thirty-six taped interviews clearly produces more data than can possibly be fully analysed in the space of any single volume. I have had to be selective in what I report and with the manner of reporting. Given the overlap in material between the two interviews per registrar, furthermore, it makes little sense simply to present data in the order in which it was gleaned. The same registrar, for example, may talk of issues concerning the diagnosis of culture-bound syndromes at two points during the first interview and at three different points during the second. I have therefore grouped material thematically rather than according to the manner in which it was collected, but indicating at all relevant points how data was obtained.

As is always the case with research which relies heavily on qualitative methods, there is always the question of how representative of the entire corpus of data collected is the material I choose to present. My response to this question is two-fold:

1. For the purposes of the current study I am interested only in certain issues, all of them bearing in some way, however indirect, on the question of race and culture in South African psychiatry. By definition, then, I am excluding material not germane to the central concerns of this dissertation, interesting though it may be. Some of the material, as I have indicated earlier, will be used for later research.
2. Each time I quote a portion of discourse I bear in mind the question of representativeness, and often, in fact, highlight inconsistencies in response. The uniform vignette structure, furthermore, gives ample opportunity for the coding of many responses in terms of proportions of registrars who speak in similar ways about given issues. The more structured aspects of the data, in other words, act as a foil to the less structured.

In presenting results in this part of the dissertation, as elsewhere, I have abandoned the convention of separating 'results' from discussion. This avoids repetition and unwieldy presentation especially where qualitative data is concerned. More importantly, perhaps, my decision to collapse results and discussion together stems from my acceptance of the theoretical principle that there is no such thing as a 'result' which by the very fact of its being viewed as such is not to some extent the product of the researcher's interpretations (see also Chapter 1).

I have divided the chapters that follow roughly according to the broad aims mentioned at the outset of this chapter. Chapter 9, then, deals with aspects of the ways in which registrars talk about patients - their 'cultures', their disorders, and the ways in which they express distress. Chapter 10 presents registrars' talk about the psychiatric system itself, its strengths and its weaknesses, and, in particular, the issues of race and culture as they are realised in the workings of the system. Chapter 11 presents an analysis of the ranking of vignettes exercise registrars undertook at the end of their second interviews. This chapter acts as both a summary of and commentary on many of the issues discussed in the chapters preceding it, and as a link to the final chapter in this part of the dissertation. Chapter 12 discusses the relationship between registrars' own professional socialisation and the ways that they talk about patients and patient care. It represents an attempt to link issues of the 'culture' of patients with the 'culture' of registrars.

Notes to Chapter 8

1. In 1986 the university issued a statement of mission which summarised its views on these issues. The statement reads (with identifying data deleted):

In view of international and national developments, the Vice-Chancellor has issued a statement which reflects his view of the position of the University, an autonomous institution.

1. The University strives to be a university of the first rank in both an international and an African context.
2. The University rejects racism and racial segregation and strives to maintain a strong tradition of non-discrimination with regard to race, and with regard to religion or gender, in the constitution of its student body, in the selection or promotion of its faculty and in its administration.

The University hopes to create an environment where inquiry and scholarship can flourish, where heterodoxy is not suppressed and where creativity can find expression. Its goal is excellence in all facets of university life: teaching, research, administration and the interface with the community.

3. In seeking the highest possible standards in teaching, the University continues
 - to upgrade the quality of teaching and teaching staff;
 - to select students on merit while recognising that special criteria may be required to identify disadvantaged students who have potential;
 - to ensure that students from a disadvantaged background are given special teaching assistance if needed after admission to the University to ensure that they can succeed and meet the high degree standards the University demands.
4. The University accepts unreservedly that a fundamental part of a University's scholarship mission should be a strong research component and orientation to add to and improve understanding of existing knowledge; to this end the University
 - emphasises research not merely development;
 - expects its teaching staff to have the capability and will to devote part of their resources to research;
 - encourages a higher proportion of postgraduate to undergraduate students than exists at the moment;
 - opposes any form of censorship which prejudices fundamental research and scholarship.
5. The University encourages each faculty, department and the administration to plan forward and establish specific strategies for the years ahead so that the University of the future will not merely be a projection of its past but will be in tune with and reflect the changing environment in which it functions.
6. As an open university, the University is dedicated to the fundamental concept of academic freedom which
 - is essential to ensure high standards of teaching and research;
 - is necessary to counter fear of heterodox thought and ideas in the continuous search for truth;
 - accepts as vital the right to determine, on academic grounds, who may teach, who may be taught, what may be taught and how it should be taught;
 - thrives best in a society which encourages frank questioning and inquiry as well as legitimate protest; a society where those who exercise these rights are protected by the rule of law.

Chapter 8: Introduction to interviews with registrars

7. The University accepts that there are physical and other constraints on its growth; it recognises that its 'optimal' size will vary from time to time depending on circumstances; it endeavours, without being restrictive, to control and contain its rate of overall growth with appropriate adjustments to the balance between faculties and departments so as to ensure the highest standards.
 8. The University encourages a high degree of faculty and student involvement in its affairs.
 9. The University seeks to be a dynamic institution aiming at excellence that will attract both the best teaching and research staff and the highest quality students.
 10. The University wishes to function in intimate contact with and to contribute to its environment. The issues that concern South Africa, Africa and the international community are of concern to the University as part of that environment. It encourages direct participation in community work where the position, training and skills of university staff and students mean that they have a particular role and opportunity. The University encourages in all its members and in society those attitudes of understanding, tolerance, and respect for others which are essential for the attainment of peace and justice in a troubled land. As a non-racial institution the University believes it has a special role to play in South Africa.
-
2. This voluntarist approach, as we have seen in Part 1, seems to have been erroneously adopted by some critics of South African psychiatry. The voluntarist approach, though, is a powerful one and difficult to abandon entirely, particularly when one is studying articulate people engaged in a discipline which emphasises the individual, as will be shown in Chapter 12.
 3. I do not wish to confine responsibility for the field of psychiatry jointly to all these disciplines either. Psychiatry is a product of a large number of socially and historically embedded forces, by no means all of which have to do with the comparatively narrow interests of particular professional groups (Fabrega, 1989b; Ingleby, 1981a; Miller & Rose, 1986).
 4. When intricacies of power dynamics are examined in particular contexts, of course, the image of the psychiatrist as having final control in any given unit may become more blurred. There are arguably units in which nursing staff, for example, wield far more power in the day-to-day running of a ward than does any psychiatrist. The fact remains however that psychiatrists are seen to be in charge and may by virtue of their professional status alone override the decisions and actions of other staff members. Their higher status is underlined by a number of factors not the least of which is their earning more than other staff members.
 5. This does not imply, of course, that psychiatrists by definition are unconcerned with such issues.
 6. Probabilities of who will treat whom are of course conditional on personal aspects of the patient and the problem. As we have seen in Part 3, people presenting at Psychiatric Casualty with overdoses during office hours (but not necessarily at other times) are likely to be seen by intern clinical psychologists, those with marital problems by social workers, always subject to these clinicians' having time to devote to them. It is extremely rare, however, for a qualified psychiatrist to assume responsibility for the everyday management of a case.
 7. In the system in question, every person who completes the registrarship training - the four-year rotation and success in Parts 1 and 2 of the professional psychiatry examinations - immediately gains the title of consultant psychiatrist, should s/he decide to remain in the system. This differs from the situation, say, in Britain, where qualified psychiatrists not uncommonly hold registrar posts.
 8. Events during the writing up of this dissertation surrounding my reporting on preliminary findings suggested that I had probably been justifiably concerned that I might not have received full participation from certain psychiatrists.
 9. I am, of course, obliquely raising the question here of the extent to which one regards professional or scientific discourse as likely to be coherent or unitary or to be indicative of what Gilbert and Mulkay (1984) have termed 'a multiple reality' (p. 188). My approach, as has been seen in Part 2 and will be

emphasised again in Part 3, supports the 'multiple reality' view. This view accords both with my experience and with my reading of texts in new paradigm psychology and medical anthropology. I discuss these later in the chapter.

10. A longitudinal study of this kind is in fact being envisaged but is not reported on here.
11. In the event, it was not possible to detect differences in response clearly attributable to length of experience. It was clear, however, that some registrars felt their responses to be influenced by the particular ward in which they were working at the time of the study, as this was mentioned to me a number of times. As patterns of ward placement, though not random, are not consistent across registrars, the fact that a registrar is working in a particular ward at a particular time does not consistently imply that s/he is at a particular juncture in the training. A full exploration of the interaction between opinions, experience, and placement would have to be undertaken through a series of longitudinal case studies.
12. Antaki's work can be seen to fall within the general ambit of psychology in the tradition of what Harré and Secord (1972) termed 'the new paradigm'. This paradigm in itself can be related to more general developments in what has been termed 'interpretive social science' (Rabinow & Sullivan, 1979). I have discussed the theoretical foundations of 'new paradigm' psychology elsewhere (Swartz, 1979), and shall not attempt any comprehensive review here. Only points directly germane to my usage of this paradigm will be mentioned.
13. B. F. Skinner (1979), leading proponent of an important school of 'old paradigm' psychology, radical behaviourism, describes well the attraction that predetermined structures of response hold. In the second volume of his autobiography he shows how he laboured at his research on conditioning of pigeons in a laboratory setting to obtain 'neat curves' in the graphs of their responses. For a more detailed discussion of this phenomenon, see Swartz (1983).
14. It should be noted that it is this context of self-consciousness about theory and its structuring role that differentiates this approach from 'old paradigm' psychology. The 'old paradigm' seeks closer and closer approximations to the truth 'out there' through methods which are viewed as transparent, and leading the way to greater and greater accumulated knowledge. The archetypal method of 'old paradigm' psychology is the laboratory experiment in which extraneous data is screened out, and which foregrounds, once again, only particular kinds of relationships between variables - and between researcher and research 'subjects' (Mixon, 1972).
15. This does not of course constitute an argument for a nihilistic relativism of the type which suggests that it is impossible to compare the efficacy of any given scientific model against another.
16. Once again, it is important to emphasise that I am not rejecting the concept that there are better and worse scientific or professional theories.
17. I am aware that in this brief discussion I have simplified the field considerably and have not given attention to debates between authors cited - for example, between hermeneutic medical anthropology and critical medical anthropology. Elsewhere in the dissertation (see especially Chapter 5) I make my cognisance of such debates clear. For the purposes of current discussion however it is sufficient to note that all these authors, whatever their differences, share common features in opposition to positivist science.
18. The issue of identity, of course, extends far beyond the realms of categories such as those of race and gender. Respondents' views are all shaped by a number of personal factors, none of which I am at liberty to reveal here.
19. Social factors in South Africa have without doubt affected even what I present here: when I began planning this study in 1983 the ideological climate in South Africa was far different from the post-1985 era, 1985 being the year of a massive upsurge of overt civil protest and violence. The events of 1985 had an important influence on the way that South African psychology saw itself and its social role (L.

Chapter 8: Introduction to interviews with registrars

Swartz, 1988; Swartz, Gibson & Swartz, in press; Swartz, Dowdall & Swartz, 1986). South African psychiatry has also responded to these events, if in a somewhat more muted way, as has been seen in Chapter 3. These changes reflect changes in ideological climate more generally. In the first half of the 1980s, for example, there was little mention in the press of the African National Congress (ANC) and similar liberation movements; today scarcely a day goes by without such mention. Awareness of the fact of unequal and discriminatory services is currently acute and talked about far more commonly than previously.

20. It should be noted that my wording of questions was not exactly standard and at times registrars answered questions before I was able to put them. This is a limitation on the replicability of my study, but the gain of asking questions in the context of as relaxed and informal an interview as possible was predicted to be an openness of response on the registrars' part. As I have mentioned earlier, I wished as far as possible to distance the situation from one similar to an oral examination.
21. In the catchment area for De Hoop and the other hospitals in the system, there are very few Indians, and these tend to be included with the 'coloured group'. It would have been inappropriate, therefore, to have produced an 'Indian' vignette.
22. This means in effect that if order of presentation is ignored there were six possible combinations of vignettes to be seen by the eighteen registrars, according to the principle illustrated below:

Combination 1:

Mr A from Arderne

Mr M from Lumko

Mr X from Myrdale

Combination 2:

Mr A from Arderne

Mr M from Myrdale

Mr X from Lumko

Combination 3:

Mr A from Lumko

Mr M from Arderne

Mr X from Myrdale

Chapter 8: Introduction to interviews with registrars

Combination 4:

Mr A from Lumko

Mr M from Myrdale

Mr X from Arderne

Combination 5:

Mr A from Myrdale

Mr M from Arderne

Mr X from Lumko

Combination 6:

Mr A from Myrdale

Mr M from Lumko

Mr X from Arderne

These six combinations are generated by allowing all combinations subject to the proviso that there is no repetition on either the horizontal or vertical axis - i.e. that no registrar receives more than one vignette for any suburb or discusses either Mr A, Mr M or Mr X more than once.

Within each combination, there are six possible orders of presentation, as I demonstrate below for the case of Combination 1 (for ease of presentation here I have adopted the following convention: in each case, the first letter stands for the name of the patient, and the second for the suburb. So: ML is Mr M from Lumko, etc.)

Possible orders for Combination 1:

AA	ML	XM
AA	XM	ML
ML	AA	XM
ML	XM	AA
XM	AA	ML
XM	ML	AA

Within each combination set three presentation orders were selected randomly without replacement so that no registrar received the same cases in the same order as any other. Unfortunately, in the case of Combination 2, selection was inadvertently undertaken with replacement, and two registrars - Drs 2 and 14 received the identical cases in the identical order. In the event, I was able to detect no order effects in the responses, so this became immaterial to my results.

Chapter 8: Introduction to interviews with registrars

23. This does not imply, of course, that useful information could not be obtained from an examination of registrars' perceptions of psychopathology in children and adolescents, particularly given the centrality of images of childhood in the current South African political climate (Brittain & Minty, 1988; Burman & Reynolds, 1986; Dawes, in press; Lawyers for Human Rights, 1986; Straker, 1989; Swartz & Levett, 1989). The variables added, however, by including adolescence as a category would have complicated the picture in the first known study of this type in South Africa.
24. I do not suggest here that women *by definition* and without exception will be immune from seeing women patients - and, indeed, aspects of themselves and other women - as 'other' any more than I argue that all Black people 'organically' and 'intuitively' understand 'Blackness'. There would be a danger of racism in one suggestion as there would be one of sexism in the other. It is however also true that local psychiatric culture, like psychiatric culture elsewhere, is dominated by men and the almost invariable assumed status of a woman, regardless of race, in the local psychiatric system is below that of a man. In this regard, it is probably instructive that in my years of working and doing research in the hospital system I have always been addressed by staff and patients to whom I have not been introduced as 'Doctor'; female psychologist colleagues often talk of being referred to (most commonly) as 'nurse' or 'sister', sometimes as 'social worker', and rarely as the high-status 'doctor'.
25. This second point in particular, of course, underlines a more general methodological and theoretical imperative running through my entire study. By turning on its head, as it were, a supposedly 'neutral' instrument like the PSE and demonstrating cultural factors about the instrument-in-use, I am simultaneously pointing to the cultural construction of empiricist psychiatry (cf Brown, 1987; Loring & Powell, 1988). Clearly, part of what I have been trying to do throughout this dissertation is to explore ways in which 'cultural' psychiatry is as much about the professional culture(s) of psychiatry as of the psychiatry of different 'cultures' of patients. The implications of my manner of use of the PSE go beyond the simple practicalities of the construction of vignettes appropriate to the current study. These implications however require full discussion in themselves and will be dealt with elsewhere than in this dissertation.
26. In the actual vignettes, the ward numbers by which the units are known at the hospital were used in the place of 'Psychiatric Casualty' or 'Medical Casualty'.
27. If anything, as will be seen, the overriding pattern such as there is in presentation of results is in reverse order - with material from the first interview tending to be presented after that from the second.

Chapter 9

Registrars' reports on patients from different backgrounds

Table of contents

I.	Introduction	222
II.	Diagnosis	222
A.	The diagnosis of Mr A	224
B.	The diagnosis of Mr M	224
1.	Diagnosing Mr M as depressed	225
C.	The diagnosis of Mr X	229
III.	Special issues in diagnosis and aetiology	230
A.	Talk of toxins and the diagnosis of toxic psychosis	230
B.	Talk of 'culture' and the diagnosis of 'culture -bound syndromes'	239
1.	Cultural dislocation as implicit pathogen	247
IV.	'Stress', family relationships, psychodynamics and the causation of psychopathology	247
V.	Concluding comments	253
	Notes	255

Chapter 9

Registrars' reports on patients from different backgrounds

I. Introduction

In this chapter I present and discuss registrars' reports about patients from differing backgrounds. The material is drawn largely from registrars' responses to questions concerning diagnosis, aetiology and other information about the subjects of the vignettes they read. The chapter falls into three broad sections, each further subdivided, and a concluding commentary. The first section examines diagnoses provided for the three vignette types, and pays particular attention to the issue of the diagnosis of depression in different race groups. The second section explores two central questions in the registrars' talk about diagnosis and aetiology: that of toxic psychosis, which is of particular local import; and that of culture, culture - bound syndromes, and the concept of cultural dislocation as pathogen. The third section explores aspects of registrars' talk about 'stress' in different types of patient, and the relationship between such talk and other views on causation of and patient responsibility for psychopathology. The brief concluding comments draw out central issues which link this chapter with those that follow.

II. Diagnosis

The primary diagnoses given by the registrars for the vignettes are presented in Table 9.1 overleaf.

Table 9.1. Primary diagnoses for the vignettes

	Mr A	Mr M	Mr X
A R D E R N E	toxic psychosis x3 psychotic x3	toxic psychosis schizophreniform psychosis x3 depression x2	toxic psychosis x2 schizophreniform psychosis x4
L U M K O	schizophreniform psychosis x2 toxic psychosis x2 mania mania/toxic psychosis	depression x4 schizophreniform psychosis schizophreniform psychosis/ depression	psychotic x2 schizophreniform psychosis x2 culture-bound syndrome/ schizophreniform psychosis brief reactive psychosis/ schizophreniform psychosis
M Y R D A L E	toxic psychosis x3 mania x2 mania/schizophreniform/toxic psychosis	schizophreniform psychosis x4 depression psychotic	schizophreniform psychosis x4 toxic psychosis psychotic

Note: For ease of presentation, I have grouped responses under headings, and have not quoted exact words. For example, diagnoses of 'bipolar affective disorder, currently manic' are reflected under the rubric of 'mania'; diagnoses of 'bipolar affective disorder, currently depressed' are reflected under part of 'depression'.

It should be noted that in almost all cases alternative (differential) diagnoses were offered. For example, every registrar made reference to a gamut of organic conditions (including

epilepsy, head injury, metabolic problems, urinary tract infections, delirium as a result of pyrexia) which need to be excluded in the diagnosis of psychiatric illness. Some registrars refused to hazard a primary diagnosis in some or all of the cases they read. Of these, some were prepared to say that the patients referred to in the vignettes were definitely psychotic, but could not commit themselves to a decision on the type of psychosis (e.g. schizophrenia, affective disorder, psychosis of organic origin); others felt that they could narrow the choice down to one of two or three categories (e.g. schizophrenia or depression). The results of these decisions are reflected in Table 9.1 above.

A. The diagnosis of Mr A

As could be predicted from the construction of the vignette in question, the most common single diagnosis attached to Mr A was that of toxic psychosis secondary to the abuse of cannabis and/or mandrax (methaqualone)¹. This diagnosis also falls under the rubric of 'psychotic' and is specifically catered for in the mania/toxic psychosis offered by one registrar for Mr A from Lumko, and in the mania/schizophrenia/toxic rubric offered by another for Mr A from Myrdale. No registrar when discussing toxic psychosis as a primary or a differential diagnosis failed to mention both cannabis and mandrax as possible causative agents. The roughly equal distribution of schizophrenia (or schizophreniform psychosis) and affective disorder, manic type, can also be seen as a reflection of the mixed picture deliberately presented in the vignette.

The differential ascription of toxic psychosis by race in the case of Mr A is interesting and will be discussed below as part of a more general discussion of the toxic psychosis issue.

B. The diagnosis of Mr M

Once again, the construction of the vignettes seems in general to have been followed, with the bulk of the diagnoses falling in the area of schizophreniform psychosis (8 diagnoses),

affective disorder, depressed type (7 diagnoses), a choice between the two (1 diagnosis), and the label of psychotic in one case allowing for either, or for any other psychotic condition. One registrar (Dr 15) labelled Mr M from Arderne as suffering from toxic psychosis. This diagnosis will be discussed below.

1. Diagnosing Mr M as depressed

Two of the diagnoses offered for Mr M from Arderne are for depression, four for Mr M from Lumko are for depression and a further one for either depression or schizophreniform psychosis. For Mr M from Myrdale the diagnosis of depression is given once. It does fall within the rubric of psychotic which was offered by Dr 8, but the registrar in question specified that though s/he would consider affective disorder (depressed type) it would not be high on his/her list². It appears therefore that the diagnosis of depression is being made most commonly in the case of the patient seen as Black, less commonly in that of the 'coloured' patient, and most rarely in the case of the 'white' patient.

Any interpretation of this observation must be made subject to the caveat that with low numbers such as these the pattern of diagnoses by race must be seen as statistically unstable and should be viewed with caution. The impression of a striking pattern, though, of all but one Black patient being labelled depressed or potentially depressed but only one white patient being seen as most likely depressed, is reinforced by some further observations.

Dr 12, who made the diagnosis of depression in the case of the 'white' patient was one of the registrars who had been given the 'Myrdale' vignette first. Dr 12 did not immediately identify the patient as white, and in discussion of the case made reference to facilities for white, coloured, and Black people. By the time Dr 12 had gone through the exercise of looking at all three vignettes, however, s/he was identifying the patients according to race as I had designed the study. Dr 12 did not wish to change any diagnoses in retrospect after

deciding that each vignette referred to a patient of a specific racial category. Though overtly unequivocal in offering the primary diagnosis of psychotic depression in the case of Mr M, in discussing facilities available, Dr 12 appears, possibly, to have been holding different implicit diagnostic pictures for hypothetical 'Mr M's of different race categories. Although Dr 12 described the care for Mr M as similar regardless of race, only in the case of a 'white' Mr M was there any discussion of facilities designed specifically for schizophrenics - schizophrenic out-patient groups, and a day centre for schizophrenics. It is possible that Dr 12 mentioned these facilities purely as a result of being under the impression (erroneous, as it happens, in the case of the day centre) that these facilities are available only to whites, and s/he was comparing facilities across race categories. It is also possible, however, that Dr 12 would have read the case of an unequivocally white Mr M as one of schizophrenia. Dr 12's primary diagnosis of psychotic depression might well have been made under the influence of the fact that s/he was at the time of my study placed in the admission ward for Blacks, and, as we discussed during our first interview, was very much affected by the experience. When Dr 12 'realised' that the label of Myrdale referred implicitly to the patient's being white, however, it may have been difficult to decide to change the primary diagnosis of depression precisely because the ideological construction of psychiatric diagnosis is that it is unbiased with respect to variables such as race (Loring & Powell, 1988). Dangerous though it is to speculate too much on the basis of the pattern of data available, it does appear possible that even the single diagnosis of depression given a white Mr M may not have been intended for a white patient.

Further evidence for this view comes from the response of Dr 2, who, like Dr 12, happened to be given the case of Mr M from Myrdale as the first vignette. Dr 2 chose the diagnosis of schizophreniform illness as primary for the case of Mr M but explicitly mentioned that were Mr M Black, some of Mr M's views could be what Dr 2 termed 'culture congruent' and not symptoms of psychosis, in which case the primary diagnosis would definitely change to depression.

It therefore seems reasonably safe to say that the diagnosis of depression in the case of Mr M was made more commonly in the case of a Black, as opposed to a white, Mr M. Further perusal of all the cases where depression was diagnosed for Mr M reveals that all the diagnoses for a Mr M from Lumko (i.e. Black) were made with little comment (though not without differential diagnoses), but that one of the two cases in which a Mr M from Arderne (i.e. coloured) was diagnosed depressed was explicitly affected by the registrar's perspective on the power and dangers of psychiatric labelling. The registrar in question, Dr 9, said:

I would primarily search for depression for the simple reason that...the labelling problem...okay I don't want to miss a depression because it is treatable...I work in hierarchical order in reverse way - as more can be done for a depressed person - my prejudice for depression - is give them the benefit of the doubt.

This statement raises a number of issues about registrars' views on psychiatric labelling and its relationship to practice, and some of these will be taken up later. More fundamentally, though, the statement does provide confirmatory evidence for the view that clear diagnoses of depression have been more commonly made without qualification for Black Mr M than for coloured Mr M (four diagnoses made without comment as opposed to one).

Registrars' apparent tendency to diagnose as depressed the Mr M from Lumko, as opposed to Mr M from elsewhere, may well be related to clinical experience. Informally in the hospital system there is often mention made of the dangers of diagnosing schizophrenia too readily in the presence of features (such as belief in spirits entering the body) which may be 'culturally appropriate'. As was shown in Chapter 2, concern about issues such as this is prominent in the South African literature on depression in Blacks. The tendency to diagnose depression more commonly in the Black case may be regarded as a reaction to perceived mistakes of the past - a phenomenon which is by no means confined to South Africa (Kleinman, 1977; Kleinman & Good, 1985; Littlewood & Lipsedge, 1989). In terms of social distance, furthermore, the Black patients are furthest away from the group of (white and coloured) registrars. Dr 9 in the quotation above speaks of giving patients the

'benefit of the doubt'; it may be the case that in dealing with Blacks the doubts are greater (a point which is borne out by the finding to be presented in Chapter 11 that registrars seem to regard their certainty of diagnosis with Blacks as the most shaky). The point I am making here may appear to contradict that which I made with respect to the diagnosis of depression in the coloured Mr M by Dr 9, where I argued that those diagnosing depression in Blacks appeared less equivocal. This is not necessarily the case if one considers a number of factors. I demonstrated in Chapter 3 that talk regarding concerns about the position of Black psychiatric patients is widespread and often powerful. A reaction to this on the part of clinicians may, regardless of whatever other 'rational' factors may be operative in the decision, be unconsciously to choose the least stigmatising label, particularly where they feel uncertain. Many registrars are acutely aware of their perceived role as reproducers of oppression. It was, for example, in discussing a vignette of a black person (though not Mr M) that Dr 16 said, 'We sedate people against their will...we're assaulting them.' He immediately added, '...Well, this happens not just, well Black people,' but it may not be altogether by chance that such an issue was raised in the context of discussion of a Black person (cf Rosenfield, 1984). In the light of this, then, if one can believe that Black people are depressed and hence both subjectively distressed and, more commonly than in the case of other diagnoses, actively desirous of clinical care, one may be able to distance oneself from the image of psychiatrist-oppressor.

None of these points undercuts the probability that there are rational reasons for the diagnosis of depression more commonly in the case of a Black Mr M. It is important however to recognise the simultaneous operation of what could be termed the irrational, and the interplay between these. As was mentioned in the previous chapter, examining professional or scientific talk similarly to everyday talk does not imply that one denies any rationality or professional accountability in this talk. It is quite possible, for example, that the registrars have, at various points, been taught by people who express their own guilt about Black people by tending to overdiagnose depression and pointing to rational justifications for doing so. Through rational application of what they have learned,

therefore, they may be reproducing an image based on over-reaction to the pathologisation of Black people. In this regard, it is interesting to note that in only one case out of all those examined by registrars (a total of 54 opinions on vignettes was obtained - three for each of the eighteen registrars) did a registrar offer a differential diagnosis that a patient may not be suffering from a mental illness at all. This was offered by Dr 7, for a Black Mr M, and where the primary diagnosis offered was that of depression.

C. The diagnosis of Mr X

As Table 9.1 shows, the most common diagnosis offered in this case was that of schizophreniform psychosis (10 diagnoses) with the same label being catered for in one 'culture'/schizophreniform psychosis option, in one brief reactive psychosis/schizophreniform psychosis option, and under the general rubric of 'psychotic' in three cases. No primary diagnoses of mood disorders (mania, depression) were offered, and in fact depression was offered as a second choice (i.e. first differential) in only one case. As might be expected from the atypical picture offered in the vignette with respect to schizophreniform psychosis (apparent visual hallucinations and/or dissociative phenomena), all registrars except for one mentioned that an organic cause for the condition must be ruled out. The only organic diagnosis offered as primary, however, (as opposed to as a differential) was that of toxic psychosis - in the case of two vignettes depicting Mr X as coloured and one depicting him as white. The atypical picture also led to the primary diagnosis of 'cultural' or schizophreniform psychosis (equally weighted alternatives) in the case of one 'Black' Mr X, and to the specific mention of the possibility of 'culture-bound' diagnoses as differential diagnoses in a further two 'Black' cases. Hysteria was offered as a differential diagnosis in the case of one white Mr X and one coloured Mr X, and brief reactive psychosis as a primary alternative in the case of one Black Mr X. Issues concerning the diagnoses of toxic psychosis and 'cultural' or hysterical psychosis are considered in a separate section below.

III. Special issues in diagnosis and aetiology

A. Talk of toxins and the diagnosis of toxic psychosis

The diagnosis of toxic psychosis by all registrars referred to a psychosis consequent on the abuse of cannabis or methaqualone or both. Table 9.2 below collates all the cases of a diagnosis of toxic psychosis by vignette and race group. It should be noted that all cases in which toxic psychosis was mentioned, however low on a set of differential diagnoses, are included under the 'differential diagnosis' rubric.

Table 9.2. Diagnoses (primary and differential) of toxic psychosis by vignette and race

	Mr A		Mr M		Mr X		TOTALS	
	P	D	P	D	P	D	P	D ^a
ARDERNE	3	3	1	2	2	2	6	7
LUMKO	3	3	0	2	0	1	3	6
MYRDALE	4	2	0	4	1	3	5	9
TOTALS	10	8	1	8	3	6	14	22

^aKey: P = primary diagnosis; D = differential diagnosis

The diagnosis of toxic psychosis, predictably, appeared as either a primary or a differential diagnosis in all cases of Mr A. Its unique appearance as a primary diagnosis in the case of Mr M reflects an idiosyncrasy on the part of one of the registrars. Dr 15 was the only one of the eighteen registrars interviewed who gave the same primary diagnosis to all three cases, and this diagnosis was that of toxic psychosis. The toxic diagnosis is offered as primary or differential in all but two of the cases of Mr X from Arderne ('coloured') and

the identical picture - all but two of the cases - can be seen for Mr X from Myrdale ('white'). One differential diagnosis in the case of a Mr X from Lumko ('Black') is offered, with five not receiving any diagnosis of toxic psychosis. In other words, the 'Black' Mr X seems to represent a reversal in pattern of the Mr X in the other two categories.

The pattern of diagnosis (primary or differential) of toxic psychosis by race and collapsed across vignettes is summarised in Table 9.3. Because of Dr 15's idiosyncratic diagnostic pattern mentioned earlier (Dr 15 alone gave the same primary diagnosis for all vignettes - that of toxic psychosis) all Dr 15's diagnoses are removed from the totals. All this does, of course, is to deflate the total of positive diagnoses for toxic psychosis by one in each racial category, which does not appear to affect the total picture greatly, but it is arguably more accurate³.

Table 9.3. Diagnoses of toxic psychosis (primary and differential) by area, collapsed across vignette type, and excluding the diagnoses of Dr 15

	<i>Arderne</i>	<i>Lumko</i>	<i>Myrdale</i>	Totals
<i>diagnosis of toxic psychosis mentioned</i>	13	9	14	36
<i>toxic psychosis not mentioned</i>	4	8	3	15
Totals	17	17	17	<u>51</u>

A chi-square analysis was undertaken to ascertain whether the impression that the diagnosis of toxic psychosis occurred more frequently for the Arderne and Myrdale vignettes (considered as a single combined group) than for the Lumko vignettes. The chi square statistic of 3.825 is greater than the critical value of 2.71 for significance at the .05 level (one-tailed test), enabling the null hypothesis to be rejected. It may be concluded that

the diagnosis of toxic psychosis was indeed made less frequently in the case of Lumko vignettes⁴.

Before this finding is interpreted, however, it is necessary to check other information. The diagnosis of toxic psychosis in the local context is essentially a diagnosis regarding aetiology. Toxins are seen to cause or at least influence psychosis in some way. The category of diagnosis, in this case, therefore, elides into that of aetiology. A perusal of the registrars' responses to questions about aetiology reveals that in general where the registrars mention cannabis or methaqualone as aetiological agents, they have already given a primary or differential diagnosis of toxic psychosis. There were however three cases, all of Mr X from Lumko, in which the drugs were mentioned as possible causative agents in the absence of either primary or differential diagnoses of toxic psychosis (Drs 2, 14 and 16). I noticed further in my interviews that at times when registrars were asked for information under the heading of 'other possible information' about cases mentioned in vignettes, they provided responses which could equally easily have fallen under the 'aetiology' rubric - for example, 'stressors' tended to be mentioned both as 'other information' and as aetiological agents. I therefore examined all the 'other information' responses and found that there was one case - again of Mr X from Lumko - in which a registrar (Dr 8) mentioned cannabis and methaqualone as part of other information which could be expected about the patient, but in the absence of these drugs' being mentioned specifically as aetiological agents or of a toxic psychosis diagnosis. Dr 8 did not specifically speak of viewing cannabis and methaqualone as causative factors, and could have seen them simply as coexisting factors. I have included the mention of these drugs by Dr 8 however in the analysis that follows, as the inclusion would tend to operate in the 'null' direction - i.e. in that of there being no difference between race groups with respect to ascription of implications of drug involvement in the condition. The revised picture is presented in Table 9.4 below.

Table 9.4. Mention of cannabis and/or methaqualone in any or all of the 'diagnosis', 'aetiology', or 'other information' categories by area, collapsed across vignette type, and excluding the responses of Dr 15

	<i>Arderne</i>	<i>Lumko</i>	<i>Myrdale</i>	Totals
<i>toxic psychosis mentioned</i>	13	13	15	41
<i>toxic psychosis not mentioned</i>	4	4	2	10
Totals	17	17	17	<u>51</u>

The picture generated by Table 9.4 is far more even across race categories than that of Table 9.3, which displayed diagnoses alone. This reworking of the data undercuts at one level the impression that registrars are less likely to diagnose toxic psychosis in Blacks than in others. This impression would be somewhat surprising in the light of allegedly high use of drugs such as cannabis and methaqualone in the South African Black population (Rottanburg, 1982), and the commonly-held view in the local transcultural psychiatry literature that Black people, currently under a great deal of 'stress', are turning increasingly to drug use (see the review in Chapter 2). One might in fact have expected the image of *higher* drug use among the vignettes labelled as 'Black', but this is clearly not the case. Another possible scenario could have been the prevalence of drug use being seen as lower amongst white patients than amongst either coloureds or Blacks both because of the perceived correlation between poverty and drug use and because of the perception that gangs and 'drug subcultures' are active in both coloured and Black areas in Cape Town. Two registrars, in fact, (Drs 2 and 17) made explicit reference to this during their interviews. The deliberately chosen mixed socioeconomic make-up of all the areas chosen for the vignettes may have militated against the view of whites as necessarily better off financially than Blacks and coloureds. Whatever the reasons, it does appear safe to say

that a close analysis reveals similar patterns of attribution of drug use across the racial categories.

The fact that this pattern of similarity emerged only after a number of categories of response were considered simultaneously raises interesting issues. Though it may be reading meaning into the pattern of data obtained, it may be possible to construct a loose hierarchy of levels at which drug use was mentioned. The level at which registrars seem most confident of involvement of drugs in the clinical picture may be seen as that of primary diagnosis - both because of the diagnosis being asked for first in each interview, and because of the importance attached to this label in psychiatric practice (and by the registrars themselves). Next on the hierarchy would be differential diagnoses, thirdly, mention of drugs in possible aetiological pictures, and, finally, mention of drugs as part of other information. Table 9.5 shows the mention of drugs by race group in this hierarchy.

Table 9.5. Mention of drugs by category and race, collapsing across vignettes, and excluding the responses of Dr 15

	<i>Arderne</i>	<i>Lumko</i>	<i>Myrdale</i>	Totals
<i>primary diagnosis</i>	6	3	5	14
<i>differential diagnosis</i>	7	6	9	22
<i>aetiology</i>	1	2	1	4
<i>other information on toxins mentioned</i>	0	1	0	1
Totals	14	12	15	41

If the implicit hierarchy I have suggested is correct, then the pattern (albeit rather weak) seems to be that mention of toxins tends to occur lower on the hierarchy in the case of Blacks than in the case of whites or coloureds. This may be related to a number of factors

including sensitivity about stigmatising Black people unnecessarily. The responses must also be considered in the light of the relationship between the registrars and me, and their possible desire not to present themselves as potentially racist in my eyes.

A further important consideration is the belief that unusual psychiatric presentations in Blacks are not necessarily of the same diagnostic significance as those in other groups. Dissociative features, visual hallucinations, and the like can all be explained under a general 'cultural' rubric among Blacks. Indeed, in registrars' discussion of every vignette about a Black patient, 'cultural' issues were raised in various ways. The relationship between use of 'culture' as a label and 'toxins' is shown in Table 9.6.

Table 9.6. Two-way table showing mention of 'toxins' and 'culture' as diagnostic category (primary or differential) or aetiological agents in discussion of Black patients. (excluding the responses of Dr 15)

	<u>Culture:</u>		Totals
	<i>Mentioned</i>	<i>Not mentioned</i>	
<u>Toxins:</u>			
<i>Mentioned</i>	6	6	12
<i>Not mentioned</i>	5	0	5
Totals	11	6	17

Table 9.6 demonstrates that in fact in every case of a Black patient either 'toxins' or 'culture' or both is mentioned. The fact that in five cases 'culture' is mentioned in the absence of 'toxins' lends support to the view that in some cases unusual or mixed features in presentation may indeed be attributed to 'culture' as opposed to 'toxins'. The overlap between the two categories suggests that they are not being used mutually exclusively, however. The fact that in 11 of the 17 cases, by contrast, only one of the categories is being applied, suggests that the terms are not simply interchangeable. Closer examination of the issue of 'culture' will be conducted in the following section.

The virtual ubiquity of mention of toxins in the registrars' responses to the vignettes reflects a number of factors, including the apparent wide use of these substances in the catchment area for Psychiatric Casualty at De Hoop. More important than this for the present discussion, however, is the fact that concern with toxins and toxin abuse represents what may be termed a cultural preoccupation of the Department of Psychiatry concerned. As I mentioned earlier, my construction of the case of Mr A was based directly on the findings of the dissertation on cannabis abuse and psychosis by Rottanburg (1982) as reported soon thereafter in an article in *The Lancet* (Rottanburg et al, 1982). It should be noted that neither the dissertation in question nor the article claims that there exists an entity such as psychosis caused by cannabis abuse, and the article in particular takes pains to point out that the methodology used cannot answer this question. The implicit motivation for the research on cannabis and psychosis in the department, however, has been to establish a link between toxin use and psychosis which demonstrates, at its strongest, the role of toxins in causing psychosis, or, at its weakest, the role of toxins in precipitating relapse in psychosis. This was frequently mentioned during the years that I was associated with the research unit of the department concerned. Emphasis on the potential toxicity of cannabis and methaqualone in the department was also important in terms of the relationship between the department and the hierarchy of the funding body for medical research in South Africa. The department concerned had recently obtained funding for a psychiatric research unit and senior staff had found that medical colleagues sitting on review committees were particularly impressed with biological psychiatric research and research which used biological markers as opposed to what was seen as the 'soft' social science type research of social psychiatry. Research and practice which could point to 'hard' evidence such as the role of toxins, measured biochemically, in psychotic illness, was thus greatly prized. Part of the way that research in the department needed to be 'sold', indeed, for purposes of further grant applications, was by informal talk about 'findings' such as those that cannabis causes mental illness over and above what could arguably be called the psychosis of a brief intoxication experience. The idea that substances such as cannabis and mandrax may cause

psychosis can, furthermore, also be viewed as part of a more general corpus of popular knowledge about the pathogenicity of illegal drugs, the reinforcement of which may of course also be attractive to non-psychiatrists on medical research review committees⁵.

These factors taken in combination and in the light of the particular education received by the registrars concerned, suggest that the diagnosis of toxic psychosis may indeed be termed an act of particular local cultural significance. The diagnosis of and talk about 'toxic psychosis' by the registrars may appear at first blush to have little relationship to 'cultural' issues as narrowly defined in dominant South African transcultural psychiatry discourse. Looked at in another way, however, the toxic psychosis category is in a real sense *fundamentally* cultural, and would remain so even had I not been able to demonstrate some aspects of its complex relationship with the overtly 'cultural' category.

Perhaps more interesting for the purposes of the present chapter than the fact that the majority of registrars seemed to use the 'toxic psychosis' category in an unproblematised way, are the comments of a registrar who has clearly given the issue some thought⁶. Dr 9 commented:

although it has been said in the DSM III they don't find too much of a category for serious marijuana psychosis - cannabis psychosis, but we are, we talk about it here so that's why I would say - cannabis - marijuana.

Dr 9 clearly recognises the conflict between the official view of the status of cannabis psychosis - that of the DSM III (APA, 1980), and that of local usage. This conflict of course is given a particular edge in the light of the fact that the DSM III is the official diagnostic manual to be used locally in all cases. Implicitly, Dr 9 recognises the power of local discourses ('we talk about it here') in shaping views of patients which may differ markedly from those constructed in pure DSM III terms - terms which do not allow for the understanding of toxic psychosis in this way. An aspect of the power of this local talk (which is of course a variant on the general power of psychiatric labelling) can be seen in

later comments made by Dr 9. The passage quoted above comes from comments on the first vignette with which Dr 9 was presented. Later in discussion of the same vignette, Dr 9 says, 'Obviously, dagga and mandrax speak for themselves', in the context of saying that these agents may have caused the psychosis. Once professional discourse has 'spoken' that these agents are indeed causes of psychosis, they then 'speak for themselves', and the hand of the local psychiatric construction of these agents as causes of pathology becomes hidden⁷.

The category of 'toxic psychosis' is of more than simply local import. Littlewood (1988) has described the use of the label 'cannabis psychosis' in an apparently racist fashion in Birmingham in England. Community workers felt that the diagnosis was being used to obtain involuntary admission for black men to psychiatric institutions. Birmingham psychiatrists, in spite of being unable to agree on the existence or diagnostic picture of 'cannabis psychosis', were making the diagnosis consistently and dramatically more often in the case of black than white patients, and, Littlewood & Lipsedge (1989) point out, in the absence of toxicological screening (McGovern & Cope, 1987a). A leading article by Littlewood & Lipsedge (1988) in the *British Medical Journal*, which reported, amongst other things, on the 'cannabis psychosis' issue, drew the response from two Birmingham psychiatrists that cannabis psychosis does not appear as a diagnosis in their current ongoing study of admissions (Milner & Hayes, 1988). Littlewood & Lipsedge (1989) interpret this change from the findings of McGovern and Cope (1987a) in the following way:

A heavily publicized survey of local psychiatrists' attitudes showed that there was little general agreement on whether 'cannabis psychosis' existed and what its symptoms might be [a reference to Littlewood, 1988]. Attempts to have a joint psychiatrist/community workers meeting were unsuccessful but one possible consequence was that the diagnosis suddenly disappeared (Miller & Hayes, 1988).
(Littlewood & Lipsedge, 1989, p. 267).

The articulation between issues of race and the diagnosis of 'toxic' or 'cannabis' psychosis is particularly salient in the South African setting, but the British findings are very

interesting⁸. For purposes of this study, it is important to note that racially patterned responses on the part of local psychiatric personnel cannot be ascribed simply to their being South African, as the phenomenon clearly stretches beyond the South African borders. What is interesting is the extent to which some South African practitioners are apparently affected by the idea that they may appear racist and hence diagnose 'high status' depression more commonly in Blacks, and 'low status' toxic psychosis if not less commonly then apparently with less confidence. Whether this in fact mirrors patterns of actual diagnosis in the Psychiatric Casualty department of the hospital system under study is at this stage an open question in need of further exploration. I unfortunately did not have access to statistics of this nature, and the figures supplied to me by Welman (personal communication), displayed in Chapter 6, do not have the cross-tabulations which would be necessary for the analysis.

B. Talk of 'culture' and the diagnosis of 'culture-bound syndromes'

In keeping with the local transcultural psychiatry literature (and indeed with much of the international literature as well, as I have shown earlier), the area of 'culture' and cultural issues was discussed by registrars as referring almost exclusively to Black patients. A differential diagnosis of 'culture-bound syndrome', '*amafufunyane*' or '*thwasa*' was offered in the case of seven of the 18 vignettes which were assumed to refer to Black people, and a further vignette received a primary (alternative) diagnosis of a 'cultural' condition (see Table 9.1)⁹. Issues of 'culture' were discussed in every case involving a Black patient (with no overt or conscious prompting from me), ranging from the argument that symptoms must be checked for cultural acceptability or otherwise, to the view that 'culture' could in some way be psychopathogenic¹⁰.

An exception to this pattern of culture's being seen exclusively as the domain of Black patients is interesting. On being presented with the vignette of Mr A from Arderne, Dr 5 immediately identified Mr A as coloured, but mentioned never having heard of witchcraft's

being alluded to by coloured people. Dr 5 asserted furthermore that belief in witchcraft did not occur among coloured people. Dr 5's response must be viewed in the light of a number of factors. As the only registrar to behave in an overtly hostile fashion towards me in either of the two interviews, Dr 5 had cut the first interview short saying that I had used enough valuable time. The first case with which Dr 5 happened to be presented at the start of this second interview was that of Mr A from Arderne, and the initial response to the vignette was, 'to me this is a complete mess'. Dr 5's mention of witchcraft as not occurring amongst coloured patients, therefore, can easily be interpreted as part of an aggressive stance towards me, or possibly even as a response to a lack of confidence in answering my questions adequately. These factors notwithstanding, however, it is clear that Dr 5 is treating 'coloureds' as a group, possibly along similar lines to the construction of such a group through the Population Registration Act.

Dr 17 was also given the Mr A from Arderne vignette, but Dr 17's response to it was different from that of Dr 5. Dr 17 claimed that complaints about witchcraft were common amongst coloured people of lower social class, and particularly amongst Muslim people. An interesting feature of Dr 17's response as opposed to that of Dr 5, is that Dr 17 explicitly divides the category 'coloured' firstly by class, and secondly by religion, thereby implicitly questioning its integrity as a unitary category. The example underlines the fact that the registrars themselves cannot be thought of as a unitary whole.

There seems to be a general acceptance among registrars that Population Registration Act categories relate to some form of 'cultural reality', particularly where Blacks are under discussion. On being presented with a vignette of a man from Lumko, for example, Dr 2 said in a joking tone of voice, 'There're not many whiteys living in Lumko so we'll assume his cultural background is as stated!' Nothing had been stated about the man's cultural background - Dr 2 was simply reading off from the word 'Lumko' something about cultural background.

What does need to be conceded in making this assertion about acceptance of cultural categories on the part of registrars is that my construction of the task played its own part. Being presented with a vignette each from three suburbs, each of which is set aside by law for the use of a group as defined by the Population Registration Act, registrars were implicitly being invited at some level to accept at least some of the legitimacy discourse reinforcing that Act. This does not mean, however, that they were always unaware of the social nature of 'cultural' categories, and the way that they are used. Dr 8, for example, had been presented with vignettes in this order: Mr X from Lumko, Mr A from Arderne, and finally Mr M from Myrdale. On reading through the final vignette Dr 8 said with a laugh, 'Again what we see here is that as the patients become paler so the history becomes more elaborate.' The use of 'again' in this context cannot refer to anything that happened within the previous context of our interview. It seems to point instead to Dr 8's experience that generally speaking more information is given psychiatric registrars about white patients referred to them in a casualty setting, than about coloured patients, and that more information in turn is given about coloured than about Black patients.

The concept and consequences of 'culture' as used by the registrars differed across registrars and in different contexts. Three registrars' discussion of 'cultural' issues in the case of Mr M from Lumko are particularly instructive in this regard. Dr 5 had chosen schizophrenia as the most probable diagnosis, with a differential diagnosis of *thwasa* (see Chapter 2 for a definition of this term), and gave three words as aetiology: 'genes, dopamine, culture.' This response suggests that Dr 5 in some sense is prepared to consider 'culture' as a pathogen (or at least a causative agent) of the same level as 'genes' and 'dopamine'¹¹.

Dr 13, by contrast, in discussing the same vignette (having given a primary diagnosis of depression and differentials of 'other psychosis' and alcohol and drug abuse), distinguished between different levels of interpretation of 'cultural' labels. Dr 13 argued that *amafufunyane* (see Chapter 2), although possibly likely to be mentioned in connection with

this case, was probably of limited diagnostic or aetiological significance. In Dr 13's experience every (Black) patient 'has' amafufunyane, and it is 'just a name you give to feeling different - just in such general use - it means just that the person's mad'. For Dr 13, therefore, amafufunyane is a pervasively used explanatory model and not an 'entity' in itself. To Dr 13 this contrasts with *thwasa* - a 'much more real magical state', an entity in itself, and having cultural integrity and acceptability to the extent that a case of *thwasa* would, according to Dr 13, be unlikely to come to Psychiatric Casualty. Dr 13's discussion of 'cultural' issues in this case, then, operates at a greater level of differentiation than does that of Dr 5.

Like Dr 13, Dr 1 opted for a primary diagnosis of depression in the case of Mr M from Lumko, saying in addition that differential diagnoses of schizophrenia and a 'culture-bound syndrome' should also be considered. An important factor in considering this case, Dr 1 argued, was that of sophistication, defined in the following way:

By sophistication I don't necessarily mean sophistication in a western sense - I mean the difference between someone who's superstitious in an ignorant way and someone who has a cultural belief in a sophisticated way.

On saying this, Dr 1 appeared uncomfortable, shifting in the chair and avoiding eye contact. It may be the case that Dr 1 was acutely aware of the possibility of being seen to be talking about Black people in an evolutionist and disrespectful way. I am unable to avoid having this impression myself about the way Dr 1 spoke but it was very clear to me from the time we spent together that he was deeply concerned not to reproduce racist assumptions at work and indeed in daily life. It also appears however that Dr 1 does not have the requisite language available to talk about Black people's attitudes towards their symptoms. The distinction drawn between ignorance and superstition does not undercut covert allusion to 'the primitive' which seems to be at the centre of the talk quoted here.

This information about Dr 1 is useful to the present argument as it demonstrates an example of a registrar clearly trying to avoid being simplistic, and displaying evidence of more careful consideration of the issue of 'culture' than, for example, does Dr 5. For all this concern, however, Dr 1 may be in the position of reproducing ultimately evolutionist views simply in the absence of knowing what else to do. Dr 1 has been placed in a position of having to make decisions about issues which seem to be the source of hesitancy and confusion. Dr 9's contradictory positions on the issue of 'culture' are interesting in this connection. In discussing the case of Mr X from Myrdale¹², Dr 9 says:

They use the word 'spirits' there - does make me think of the African population... that's the sort of thing they would tend to talk about - it also shows how important it is to categorise people - racially into the African people or coloured people - so-called coloured or so-called white - the spirit thing automatically makes me think this guy might be African in which case then a whole different scenario suggests itself - obviously the difference in the whole way we are forced to do things in this country.

Dr 9 makes a number of assertions in this extract:

1. 'Spirits' make me think of the African population (i.e. the appearance of the term 'spirits' tends to make Dr 9 assume that Mr X is Black).
- 2a. It is important (for psychiatrists as diagnosticians or more broadly) to categorise people racially.
- 2b. If Mr X is African a whole different scenario suggests itself (Dr 9 will diagnose differently if Mr X is Black).
3. We are forced to 'do things' by race in this country - this is imposed upon us and may not necessarily be the best way of doing things.

The apparent about-face on the clinical usefulness of racial categories which occurs between assertions 2b and 3 is prepared for by Dr 9's self-correction of 'coloured' to 'so-called coloured', and the subsequent use of 'so-called white'. The term 'coloured' in South

Africa has attracted particular attention as a racist label, as it may be seen to imply the existence of a homogeneous, bounded group. 'Coloured' people have resisted the use of the label, and the prefix 'so-called' or the use of fingers to denote quotation marks when the word 'coloured' is mentioned in spoken language have become commonplace. The use of 'so-called' has generalised to other racial categories, with 'coloured' remaining the paradigmatic case. In the previous interview with me, Dr 9's acute awareness of issues of race and racism was clear. This seems to be affecting Dr 9's talk about race¹³.

Further light is thrown on Dr 9's complex discussion of issues of race and culture through a discussion of possible problems in treating Mr A from Lumko. Dr 9 feels that Mr A may lack 'insight' and may refuse treatment - something which is ascribed to:

Dr 9: The problem he may well have of looking at outside problems - at relating his problems to stress as opposed to maybe blaming it on things like witchcraft...I do not agree with... I do not fall into that 'cultural' - that sort of viewpoint of emphasising cultural factors ... I although maybe I need to look at that a bit more closely as to whether he does in fact need to go to see a witchdoctor . I won't stop him from going to a witchdoctor but I won't get actively involved in it.

LS: Why don't you fall into that category...You obviously...

Dr 9: ...Because I see it as being more... I like to see the three... I like to see all the population groups as one basically - as the human group, and I feel that if someone's saying they're bewitched I see this more as a paranoid thing, more than as a specific cultural problem...I don't see it like that, for example I just had a patient who's got problems say with their Jewishness ...I do not see it as being a Jewish problem ... I see it as being...I see it from a humanistic perspective... that's a general human problem.

LS: So then you'd see the argument that Black patients are like that, white like that, coloureds like that - you'd see it as evidence of a racism?)

Dr 9: Yes in fact I'm aware that there might be a reaction from the patients to being treated differently - given say specialised treatment in some way or another.... What I'm saying is I see the DSMIII applying equally well to all patients - that's - maybe I'm totally wrong here but that's the way I am at the moment but maybe I need to do more working on this I see a difference in content here but not in form - in other words it won't bother me that he's used the word witchcraft I won't go for the witchcraft *per se* ...I'd like to see how he explains that...if it's explained in a non-understandable kind of a way with flattened affect and lack of insight, then I would ...that's what I'd go for, I'd look for the way it's presented rather than the actual content - I'd de-emphasize the content.If you look back say at the previous history of England - people were involved in witchcraft and that wasn't psychotic for

Chapter 9: Registrars' talk about patients

most people but if you had a certain group of people who were psychotic - form of the way they present suggests psychosis.

I shall not try here to do justice to all the complexities of what Dr 9 is saying, but shall focus on issues germane to the present argument. Dr 9's emphasis on universality in diagnosis regardless of the patient's background contradicts his/her earlier quoted view that 'it also shows how important it is to categorise people - racially into the African people or coloured people - so-called coloured or so-called white'. The lengthy discussion of the 'form' versus the 'content' of witchcraft, furthermore, stands in contradistinction to Dr 9's earlier mentioned views on spirits. The fact that these contradictions do occur, however, cannot be simply written off as evidence of 'unclear thinking' or similar pejoratively-cast ascriptions. Dr 9's struggle with the issues of race and culture, on the contrary, can be read to provide central information about the position of the registrar as reluctant reproducer of ideology.

There seems little doubt that Dr 9's experience of patients from different backgrounds is different. Two contradictory discourses, both informed by liberalism (Gellner, 1985; see also Chapter 4), seem to be shaping Dr 9's response to this experience. The first of these is a discourse of relativist tolerance, which allows for patients to make use of alternative healing systems (the 'witch doctor', as Dr 9 puts it, using what is commonly seen as a pejorative term but not necessarily with any intent to malign). The second of these discourses is that of universalism - all people are equal and are definitely so in the eyes of an 'objective' instrument such as the DSM III. Part of Dr 9's attempt at *rapprochement* between the two positions is by allusion to the form/content distinction in the classification of symptoms. This distinction has an illustrious history in British psychiatry and psychopathology, goes back as far as Kraepelin (Littlewood, in press), and is used as a basis for justification of the Present State Examination (Wing et al. 1974). In introducing the form/content distinction Dr 9 recalls as well evolutionist approaches to the understanding

of psychopathology and the concept of the person - modern Black people are seen to hold beliefs similar to those held by British people in previous centuries.

If one were to analyse Dr 9's utterances on issue of culture and race from a purely cognitive, rationalist perspective, one could soon come to the conclusion that Dr 9 is applying mutually inconsistent models simultaneously, and not operating according to acceptable scientific rules. An alternative perspective could be that Dr 9 is attempting to create an elaborate smokescreen for morally indefensible prejudices, prejudices of which Dr 9 is only too well aware. Both these lines of argument, in my view, seriously degrade the data at hand, and also close off discussion about the issues of race and culture at the very point at which it should begin. The solutions offered by the rationalist and moralist views are clear: from a rationalist perspective, Dr 9 should be more consistent, and from a moralist perspective, Dr 9 should be more morally pure. A more fruitful perspective from which to view Dr 9's clear inconsistencies is one which takes into account the fact that s/he, like all registrars, is socially embedded, and responding to a series of demands, not all of them overt, not all of them conscious. It may be tempting to view difficulties such as those evident from Dr 9's talk as 'errors' of intent or as deficiencies of a desocialised entity of professional or clinical judgement. To subscribe to such a view would be to fail to take the difficulties seriously as indicative of true dilemmas which may face clinicians. These difficulties, it should be stressed, probably affect even clinicians who are both morally above reproach and intellectually exceptionally skilled. The responses of Dr 9, specifically when talking about 'cultures' purportedly belonging to people different from him/herself (Black patients), must be seen as cultural products in themselves (Thornton, 1988). They reflect graphically the contradictory ways in which 'Black madness' is, and continues to be, constructed by and for biomedical professionals given the task of caring for the 'mentally ill'¹⁴.

1. Cultural dislocation as implicit pathogen

In eleven of the eighteen vignettes seen to refer to Black people, registrars said that the patient had probably recently come to the city from a rural area, with the Transkei (a 'homeland' for Xhosa people) being mentioned specifically in all but one of these cases. Registrars volunteered that a considerable part of their work with Black people involves dealing with psychiatric casualties of massive urbanisation. As was also well-known to the registrars, the majority of people who come to urban areas to seek work are very poor indeed and more often than not do not find the work they seek (SAIRR, 1988; Wilson & Ramphela, 1988). The scenario of a recent move coupled with unsatisfactory living conditions, poverty and unemployment was often mentioned by registrars, but it is interesting for the present discussion that these material issues were never discussed without reference to 'culture' as well. 'Culture' in this sense refers to an hypothesised 'true' or 'natural' state of the Black person, and it appears implicit in the talk of some registrars and explicit in the talk of others that it is the loss of this 'culture' that is seen as truly pathogenic. Dr 2, for example, explicitly mentions 'cultural dislocation' as a cause of schizophreniform illness, and adds that somebody who has a 'tribal religion background' has lost track of healing rituals. In this type of talk it is possible to see 'culture' as opposed to, say, 'poverty' as a primary explanatory device to account for psychopathology, with the powerful discourse of transcultural psychiatry being reproduced. The concept of cultural dislocation as a pathogen raises the more general question of how registrars view social origins of psychopathology. This issue is discussed in the following section.

IV. 'Stress', family relationships, psychodynamics and the causation of psychopathology

The word 'stress' or 'stressor' was used explicitly in registrars' discussions of ten of the eighteen vignettes about Blacks, in six of the eighteen vignettes about whites, and in five of the eighteen vignettes about coloureds. Closer examination of what registrars actually said however, reveals that every discussion of a Black patient uses the concept of a stressor

beyond the control of the patient as at least partly responsible for the condition. The concept of psychopathogenic stress external to the patient's control is used in a total of seven discussions of white patients, and in nine discussions of coloureds. Under what may be seen as the general rubric of 'stress' for Blacks are to be found categories such as unemployment (as a result of lack of jobs and not of something intrinsic to the patient), relocation, poverty, and overcrowding. Overcrowding, unemployment and poor social supports are mentioned as stressful in the context of discussions of four coloured patients. The term 'stress' is in general not expanded on when registrars discuss white patients. In one case, the patient is identified as a medical student who has 'gone crazy due to pressure' and who is living in poor financial circumstances in a commune (Dr 18 discussing Mr M from Myrdale).

The concept of stress as pathogen, then, seems to be applied invariably to Black patients, and approximately half the time to whites and to coloureds. Given the social background generally assumed in the case of Black patients, reliance on stress concepts is probably inevitable. There are deeper issues at hand here, however. Young (1980) has argued that the discourse on stress plays a part in reproducing what he terms 'conventional knowledge'. One way in which this may be happening here, and which is not dealt with in detail in his very full schema, is that stress is seen as referring to agency external to the person. Black people appear to be more likely to be viewed as 'victims' of stress than as agents of their own psychopathology. There is a parallel here with the analysis of victimological discourse which Levett (1989) provides in her discussion of the image of the victim of child sexual abuse. If Blacks are consistently spoken of as 'victims' of pressure, this tends to lead discussion away from the possibility of their own role as agents in their psychopathology, but also, ultimately, by implication, in their lives. The universal attribution of stress as causing breakdowns in Blacks recalls the statement made more than once in ward-rounds I attended by staff that 'if I'd had to cope with the life events the patient has had, I'd also be crazy.' There is of course much to recommend this construction from a humanistic perspective, and it could not be further from the image of South African psychiatrists'

seeing Black patients as degenerates. The notion of that Blacks may be affected and, possibly, moulded by external agents does, however, give them a lowered status in the biomedical context. Discussing what she terms 'tenacious assumptions' in western medicine, Gordon (1988) argues that in the individualist context of western medicine, 'To be [seen to be] socially determined is to be [seen to be] weak, trapped, limited' (Gordon, 1988, p. 35).

The implications of talk of stressors are even more salient in the psychiatric context, and specifically in the context of the registrars' discussions of the vignettes. Talk of stressors, it appears, submerges talk of internal dynamics - the workings of the mind much valued by any school of psychiatry even vaguely influenced by psychoanalysis. In ten of the discussions of white patients and in eight of those of coloureds, registrars make reference to what may be termed psychodynamic or family-relationship factors as important aetiological or concomitant agents. Some examples of these statements (one for each vignette of a coloured or white patient) are paraphrased as follows:

- There is probably a poor relationship with mother, a double bind situation, and high expressed emotion (Dr 11 on Mr A from Arderne)
- There are probably marital problems causing this (Dr 9 on Mr M from Arderne)
- Family relations are probably poor: a posse from the family probably dumped him in casualty (Dr 7 on Mr X from Arderne)
- Family relationships are probably poor (Dr 10 on Mr A from Myrddale)
- The man probably has an overinvolved wife and poor boundaries with his children (Dr 12 on Mr M from Myrddale)
- Mother was probably overinvolved, there are a lot of double messages, and a chaotic family (Dr 11 on Mr X from Myrddale)

By contrast, family or psychodynamic factors as pathogens for Black patients are mentioned by registrars only three times. The first example is in Dr 13's discussion of Mr M from Lumko. Dr 13 speculates that Mr M has probably lost a father (through death) as,

according to Dr 13's estimate, 85% of patients in the acute psychotic ward for Blacks have lost fathers in this way. The second example is in Dr 17's discussion of the same vignette. Dr 17 suggests that Mr M may be separated from his wife 'through no choice of his own'. This is a probable implicit reference to South African influx control legislation which although officially abolished rears its head in other forms all of which are designed to keep economically unproductive people as far as possible out of 'white', urban areas, as was seen in Part 1. Dr 17 comments further that many men do not cope with being separated from wives, once again, 'through no fault of his own'. Dr 14's discussion of Mr X from Lumko is unique in that it is the only discussion of a Black patient which uses the concept of family functioning as a pathogen without a rider that in some way or other the patient or the family cannot be blamed for what has occurred.

The registrars' talk of family dynamics and psychodynamics as implicated in the aetiology of psychopathology seems to differ, then, across race categories, with Black vignettes being spoken of in this way less often than white or coloured vignettes. Not only, furthermore, does a difference in frequency seem to be occurring, but also a difference in the type of talk. In all the cases where family and psychodynamic factors are described as aetiologically important for coloured or white patients, it is possible to read into the registrars' statements that either the patients themselves, or family members, or both, are at least in part responsible for their now being mentally ill. 'Overinvolvement', 'poor family relationships', 'double bind', and so on, are all implicitly pejorative terms, whatever their supposedly neutral 'scientific' meanings. Two of the three cases of Blacks in which family factors are mentioned, by contrast, involve situations beyond the control of either the patient or the family. Dr 13 discusses the death of a father as important without any implication that the father or the patient or anyone else in the family may have been responsible for this. Dr 17's discussion of marital separation as pathogenic is emphatic about the patient definitely having no responsibility for his circumstances, as can be seen by the repetition of syntactic pattern, 'through no choice of his own' and 'through no fault of his own'. Dr 17's discussion of separation, furthermore, could arguably be placed simply

under the rubric of the 'stress' of relocation as a consequence of the unequal structure of South African society. Dr 13's comments on the death of a father could be read in a similar way, because of the lower life expectancy for Black South Africans as opposed to others, and the proportionally higher death rate through trauma (Seedat, 1984). A more cynical reading of Dr 13's comment could be that it demonstrates a belief that Blacks as a group are emotionally more vulnerable to the death of a father than are others, but the context of my interactions with Dr 13 leads me to be confident that this view is probably not held at all, and that if it is, it is at a deeply unconscious level.

The overall picture of Black patients' and their families' being assigned less ascribed responsibility or blame for their conditions than is the case for whites and coloureds can be interpreted in a number of ways:

1. It is possible that registrars work with an implicit hierarchy of causation and view social stressors as fundamental in causing psychopathology and overriding any talk of more particular factors. An examination of the responses given by registrars tends not to support this impression - in a number of cases, white and coloured patients are seen to be affected by major social stressors and by family dynamic factors (Dr 15, for example, sees Mr M from Arderne as likely to be affected by both overcrowding and a symbiotic relationship with his mother).
2. There may well be a link between registrars' tendency to focus on external stressors in the case of Blacks and their probable tendency to de-emphasize 'toxins' (cannabis and methaqualone) as primarily responsible for the psychotic states of Blacks. Both tendencies can be explained in terms of a desire not to be seen to be blaming Black people for their illness, and to be sensitive to their situation (once again, the antithesis of the image of the South African psychiatrist who bears Black patients ill will). A less

charitable construction of this same interpretation is to say that registrars are affected by liberal guilt about the oppressed.

3. Less obvious than either of these interpretations, but closely related to the second, is the observation that to focus on external stressors in the causation of mental illness is to defocus from the internal world. This allows one to contemplate a mode of understanding Black patients which does not require a deep empathy with them. The causes of their illness can be seen to lie in external factors so obvious and so shocking (as indeed these factors are) that it is not as necessary as it might be in the case of other patients to engage with the problem of developing a subtle understanding of the family life and internal world of people who seem very foreign. It may, then, not be possible to talk intimately with a Xhosa-speaking person through an interpreter, but if the problems are attributable to concrete, external causes, it may not be necessary to do so. A variant on this argument is the observation that if one does not have to or is unable to delve closely into the internal world of Black patients, one does not have to engage with questioning the limits of the stereotype that Black people do not introspect or that they lack psychological sophistication.

One could push this line of discussion even further by suggesting that in some way Blacks are viewed as not suffering from 'real' mental illness. This argument could draw support from two sources. Firstly, registrars commonly state the need to establish whether a particular form of behaviour is culturally acceptable, implying then that some of the behaviour that they would otherwise be labelling as mental illness may in fact simply be behaviour foreign to the registrar. Important though this relativist perspective may be clinically, it carries with it a series of assumptions which may not be entirely incontestable - including, potentially, the view that there is no such thing as 'madness' amongst 'primitive' people (Murphy, 1976). Secondly, further examination of what may be termed 'hierarchies

of internality' as regards ascription of cause of psychopathology reveals an interesting parallel between talk of Blacks and talk of 'true' psychopathology on the part of some registrars. As we have seen, Blacks tend to be spoken of as affected by external stressors more than do others. Some registrars, in addition, seem to see cases of 'true schizophrenia' or 'process psychotic illness' as less importantly affected by stressors than are other conditions. In discussing Mr X from Lumko, for example, Dr 16 says that if the patient is truly suffering from schizophrenia, then it is likely that the current breakdown has been caused by genetics and ongoing social relationship factors. If however, toxic psychosis is the diagnosis, then 'severe social stress' is likely to be the cause. This argument is echoed by Dr 9's assertion (in discussion of Mr X from Myrdale) that if the diagnosis is schizophrenia, Dr 9 tends to look less for stressors and more for psychodynamic factors, and Dr 2's similar statement (in discussion of Mr M from Myrdale) that in cases of schizophreniform psychosis, dynamic factors tend to be sought but in 'reactive conditions', stress factors will be more carefully considered¹⁵. These statements are too few for the drawing of any general conclusions, but they do suggest that the question of whether registrars view Blacks as suffering from 'true' mental illness could be fruitfully explored further.

V. Concluding comments

The observations made at the end of the previous section raise interesting fundamental questions. To what extent does the dualism so much a feature of most South African transcultural psychiatry, and indeed, of apartheid society as a whole, influence registrars to the extent that they view the realm of 'Black madness' as entirely separate from that of other madness? Can it be that the desire to be sensitive to cultural difference (a laudable, but clearly not uncomplicated, aim) may actually play a role, to whatever extent, in disempowering registrars from using what skills they do have when working with Black patients? Are these skills viewed as totally irrelevant to Black people? Is it possible, in a sense, that the 'baby' of psychiatric expertise may be being thrown out with the cultural

Chapter 9: Registrars' talk about patients

'bathwater'? In the absence of data evaluating registrars' clinical competence in their work (with all the methodological challenges that that would entail), I am not in a position to answer such questions. The chapter which follows will make clear, however, that such questions are by no means irrelevant to the way that registrars talk about issues of race and culture in psychiatric care.

The material presented in the current chapter should go some way towards dispelling any notion that registrars think about issues of race and culture as they affect patients in a uniform or simplistic manner. It is also the case that at practically every point of discussion it is impossible adequately to address registrars' views on patients' 'culture' without at the same time examining issues in the construction of professional culture. This can be seen most clearly in discussions about toxic illness, stress, and psychodynamic and familial causes of psychopathology. All discussions, however, even about diagnosis of supposedly universal functional illnesses¹⁶ such as depression, cannot be understood without an examination of where the registrars themselves are placed culturally. This observation is central to this entire dissertation and will be expanded on in the chapters which follow, and particularly in Chapter 12.

Notes to Chapter 9

1. Henceforward, except where explicitly mentioned otherwise, the word 'toxins' will be used to refer to either or both of these two agents, and 'toxic psychosis' to a psychotic condition allegedly caused by the ingestion of either or both. I recognise that the words 'toxin' and 'toxic' can refer to a range of other agents, but I am following the usage of my subjects.
2. I am aware that my decision to use non-sexist personal pronouns when referring to registrars (whom, as I have mentioned earlier, I do not wish to identify by gender) may read less easily than the use of 'he' to refer to either gender. Where possible I have recast sentences to avoid the use of 's/he' or 'his/her'. Sometimes, however, this is unavoidable.
3. Because of Dr 15's idiosyncratic approach to diagnosis of the vignettes, his responses are removed for the purposes of most of the analyses which follow. In each case, the salient variable under discussion is that of race, and Dr 15's idiosyncratic response pattern is uniform across this variable. Removing his responses does not therefore constitute skewing of data in such a way that it affects my interpretation.
4. Two issues need to be mentioned from a statistical point of view in connection with this conclusion. The first is that, in keeping with modern opinion, Yates' correction for continuity was not used (see Howell, 1987, pp. 132-133, for a discussion of the debate). The second is that a one-tailed test was employed in preference to a two-tailed because my alternate hypothesis was unidirectional. The objection can be raised that this alternate hypothesis was not generated fully prior to use of the test, and that a two-tailed test would have been preferable. Once again, this is a matter of debate (see Howell, 1987, pp. 139-140). Had I indeed used a two-tailed test, the critical chi squared value for the .05 level would have been 3.84, marginally above my 3.825 observed figure. The level of certainty in rejection would then drop to slightly below 95%. This does not make an appreciable difference to my argument as it is chiefly with qualitative aspects that I am concerned. Some conventions, in any event, regard the .10 level as acceptable for significance in tests such as these, and a two-tailed test in this case clearly falls into the 10% rejection area.
5. I am not claiming here that this belief is necessarily false - I am not in a position to judge - but simply that the belief may be commonly held in the absence of proof.

It is beyond the scope of my argument to discuss in any detail the function of talk about illegal drugs in discourses about psychosis in the local and international media, but two points about the way that drugs of this kind are viewed in the local context are relevant here:

- i) The most recent new unit to have been opened by the Department of Psychiatry at the time of the study was a Drug Counselling Centre which was given and continues to receive considerable publicity in the local media particularly as a major figure organising funding for the project is a very well-known public personality whose son is a former drug addict.
- ii) Over some years I have been able to demonstrate informally the power of popular beliefs in shaping trainees' views on the relationship between drug use and psychosis. Using an abbreviated vignette method similar to that I have adopted for the current study, I have given groups of senior and graduate students in the areas of psychology, psychiatry and logopaedics, a truncated summary of the findings reported in the Rottanburg et al (1982) article.

The vignette reads:

Two groups of psychotic patients are admitted to a psychiatric hospital. The groups are identical in every respect except for the fact that Group A has been taking [substance] prior to admission whereas Group B has not. Group A is found to have an atypical psychosis and to recover more quickly than does Group B.

The question students are required to answer is:

Chapter 9: Registrars' talk about patients

What are some possible interpretations of this story?

Each time I do the exercise, I divide the students into three groups, giving the first group a vignette with the word 'dagga' (South African local word for cannabis) in the [substance] place, the second group a vignette with the words 'homeopathic remedies' in the [substance] place, and the last group the words 'psychotropic medication'. The unsurprising and invariable result (I have conducted the exercise approximately eight times) is that dagga is always seen as a psychopathogenic agent, homeopathic remedies, far less commonly so, and psychotropic drugs almost never.

6. I am not of course claiming that others had not thought about this issue. All I am able to report is that they did not discuss such thoughts with me.
7. The relationship between the 'toxic psychosis' and 'culture' areas could doubtless be further elaborated by the addition of gender as a variable to the vignettes. Informal talk with psychiatric staff and observation at ward-rounds suggests that it may be the case that Black women who present with unusual symptoms are more likely to be seen as 'hysterical' or suffering from 'cultural' conditions, whereas Black men tend to be seen as suffering from 'toxic psychosis'. At this stage, however, talk of this kind must remain speculative and further exploration is needed.
8. Two recent articles from the USA describe high rates of substance abuse on the part of patients referred to inpatient and emergency services, but they do not use the term 'toxic psychosis' or anything similar, and do not view substances as primary pathogens (Barbee et al, 1989; DeMilio, 1989).
9. Dr 3, furthermore, on being presented with the vignette of Mr X from Myrdale first, said, 'Well I think first of all it would depend on whether or not it was a Caucasian man or a Black man. It would certainly affect my immediate, or my first projection of the diagnosis.' Dr 3 then went on to say that were this Mr X Black, the diagnosis would be '*thwasa*'.
10. The single ostensible exception to this pattern was Dr 3's discussion of Mr A from Lumko, in which culture was not mentioned. It has been noted above, however, that on being presented with the first vignette of Mr X from Myrdale, Dr 3 entered into a discussion of the importance of culture in diagnosis, and provided a primary diagnosis of '*thwasa*' for a Black Mr X. If the exercise involving the three vignettes is viewed as a whole, therefore, Dr 3's response cannot be seen as exceptional.
11. 'Genes' and 'dopamine' of course operate in themselves at different levels of explanation, but they are arguably both located in a biological, relatively asocial discourse.
12. This was the vignette presented first to Dr 9, and was not initially read off as being about a white person.
13. The term 'African', furthermore, is commonly thought to be a less offensive term than 'Black', particularly as 'Black', as a specific term which replaced 'Bantu' in the Population Registration Act, is associated with state policy.
14. These observations underscore the fact that a 'mentalist' approach to the understanding of registrars' accounts cannot provide as satisfactory an interpretation of them as one which explores these accounts as data of social intercourse.
15. There is of course an element of circularity here: conditions which are diagnosed 'reactive' are then said to be 'reactions' to stressors, but this fact is not of central concern to the current argument.
16. Universal according to dominant British empirical psychiatry and even transcultural psychiatry as typified by the work of Leff (1988).

Chapter 10

Registrars' talk about psychiatric services, culture, and race

Table of contents

I.	Introduction	258
II.	Care of the patients mentioned in vignettes	258
A.	Patterns of care and racial segregation	258
B.	Pressure on services and unpleasantness of facilities	260
C.	Containment, care and control	264
III.	The prospect of integration of services by race	270
IV.	Registrars' talk about other issues concerning race and psychiatric services.	279
V.	Concluding comments	283
	Notes	284

Chapter 10

Registrars' talk about psychiatric services, culture, and race

I. Introduction

In the chapters reviewing the South African literature on transcultural psychiatry, I have discussed ways in which South African authors write and theorise about culture. For purposes of this part of the study, by contrast, I was less concerned with registrars' theoretical or academic understanding of issues of 'race' and 'culture' than with the way these issues realised themselves in registrars' experience of their every day work. I shall begin my discussion of this issue by exploring aspects of registrars' responses to questions about services for the patients mentioned in the vignettes. Following this discussion, I examine, more generally, responses both to vignettes and to a question in the less structured interviews concerning integration of services by race. All registrars, through much of their training, work in units segregated by race (See Appendix A for a description of the units in the psychiatric system). The question of integration of all hospital services by race was topical at the time of the study¹, and would affect the daily lives of the registrars. Responses to the question allow for exploration of some otherwise potentially hidden features of beliefs about culture and psychiatry. A detailed comparative examination of some registrars' responses is presented. The subsection following that explores other issues in registrars' talk about 'race' and 'culture', and the brief concluding section makes the link between the current and subsequent chapters.

II. Care of the patients mentioned in vignettes

A. Patterns of care and racial segregation

When asked about the care patients were likely to receive, registrars responded according to a reasonably fixed pattern: the patient (regardless of vignette) would be admitted to Psychiatric Casualty for a short period (overnight to two days), observed, sedated if

necessary, and put through batteries of tests where appropriate. Collateral information from relatives and others would be sought. Where necessary (and this was seen to be so in by far the bulk of cases), patients would be referred to a psychiatric institution where treatment would be undertaken over a period generally speaking of not more than three months on an inpatient basis. Thereafter, patients would be followed up in the community either at outpatients departments or at satellite clinics. There were some minor deviations to this pattern - for example, Dr 15 suggested that it would be better to manage all of the three cases on an outpatient basis - but the general pattern is preserved. A number of registrars made wry or angry comments about having to send patients to racially segregated institutions, but only in three cases did registrars volunteer that they would try actively to bend rules (formal or informal) to have the patient admitted to a hospital unit catering officially to another race group. One of these cases concerned Mr M from Lumko, who according to Dr 17 could possibly be sent to Spring Valley 'if he verbalises well' - presumably in English or in Afrikaans. This is interesting because although Spring Valley's official policy is that it caters to all races it remains a hospital in its conception designed for coloured people, and access to it for Blacks may be filtered by such issues as foreign language proficiency. Dr 3's discussion of attempting to have Mr M from Arderne admitted to the white side of Eagle's Nest demonstrates a political issue of a different kind:

Dr 3: You see, but the situation at the moment here is that this being a coloured man one is obliged to see him too politically in the current system you see, in which case I would have to do that.

LS: But...but you wouldn't choose to do that if you...if you had a free choice you wouldn't choose that.

Dr 3: (tape inaudible, but I recall his saying the man would have to go to Spring Valley)

LS: So... but he will probably have to go, but you won't be forced into admitting him...

Dr 3: No...no I think if this man was a um...was convenient for him to be here at Eagle's Nest, I would send him.

LS: You would?

Chapter 10: Registrars' talk about services

- Dr 3:* If it's more convenient for him to be admitted here I would (words inaudible) that's where his family are² (*words inaudible*). Yes I think its... uh something we would have to...to ask the family.
- LS:* Would there be any problem?
- Dr 3:* Well you know, you're speaking to me now as a registrar, obviously I need to get permission for this. If, for example, consultants who say, 'Sorry we can't take this man, he's got to go to Spring Valley,' my...my decision or my action would be not to argue - I think just for a very simple reason that the man needs to be managed as uh...as a medical-cum-psychiatric emergency. This man is either on the verge of a psychotic breakdown, or he's already in it, and that is the priority.
- LS:* Hm...So you...you...it wouldn't be entirely your decision.
- Dr 3:* No, it wouldn't be my decision - not as a registrar.

This is an interesting exchange as it demonstrates the extent to which a registrar is unhappy with the status quo as far as hospital segregation is concerned, and this registrar's belief that it is the right of this coloured patient to be admitted to a 'white' ward. The registrar, however, has only limited power and does not make the final decision - this is up to the qualified consultant psychiatrist. Dr 3 adopts the strategy that if there is to be conflict about the question of sending Mr M to a white hospital then it is better to step down and accept admission to a coloured hospital. This decision would be taken, according to Dr 3, not through any weakness on Dr 3's part, nor through lack of conviction that admission to the white hospital would have been preferable. The key issue here is the welfare of the patient as a 'medical-cum-psychiatric emergency'. Concern for the needs of the individual patient overrides any temptation to make a broader political stand on this issue. The phenomenon of registrars' being able to see aspects of their working lives as political, but not in the end acting on these issues in a political manner is discussed further in Chapter 12.

B. Pressure on services and unpleasantness of facilities

Pressure on in-patient facilities was a common theme. Every registrar mentioned problems because of lack of services or staff, pressure on beds, or unpleasantness of surroundings in

hospitals. At its most muted, this concern was expressed by Dr 5 who mentioned that Mr X from Myrddale, although probably a suitable candidate for direct admission for an open ward, would probably go first to a locked ward to wait for a place in an open ward to become free. At its most strident, the concern, interestingly, took on the metaphor of a medical condition about to erupt. Discussing the psychiatric casualty unit, Dr 8 said that it

is like a boil you know - it's like a big massive boil about to burst and you know the reason is there's so much pressure on the unit to my mind exemplifies the problem of community services.

Dr 8 ascribes the pressure on the casualty unit, then, to lack of community resources, leading to a 'revolving door' of returning patients³. As regards the same unit, Drs 7 and 15 mentioned that there were insufficient staff to deal with aggressive patients, especially at night. Drs 2 and 4 alluded to a problem of lack of space which leads, according to them, to a greater number of admissions to psychiatric hospitals, as patients are not given adequate time for observation and settling in the casualty unit. Dr 11 joked, 'In [Psychiatric Casualty] we don't think - we just do!', and felt that patients did not get the benefit of unhurried decisions.

Patterns of registrars' attributions concerning adequacy of care for patients mentioned in the vignettes were recorded at the end of interviews. They will be discussed in the following chapter (Chapter 11). It is interesting however that no registrar commented on unpleasantness of the physical environment at the recently-built Spring Valley Hospital, although Dr 4 did mention that in his view patients tend to stay too short a time because of pressure on beds. There was one comment about the unpleasantness of the physical environment of the locked male ward on the white side of Eagle's Nest (Dr 12), one comment about the atmosphere being unpleasant (Dr 4), and one comment on the high quality of the facilities in the open wards on the white side (Dr 8). Eight registrars (Drs 2, 9, 10, 12, 13, 14, 17 and 18) commented on the unpleasantness of the facilities for Blacks at Eagle's Nest, with Drs 17 and 18 both describing the environment as not conducive to

recovery, and Dr 13 expressing concern about the level of overcrowding. Both Dr 2 and Dr 18 drew a distinction between the quality of the physical environment and the good quality of professional care available. As Dr 2 put it, referring to a Black patient, 'He might have to sleep on the floor but he'd get what he needed!' It should be noted here, however, that until the end of their interviews, registrars were not asked to make any explicit comparison between facilities available to the characters of the vignettes. Nevertheless, the spontaneous pattern seems to be more consistent dissatisfaction expressed with regard to facilities for Blacks than for others. All registrars, in addition, spontaneously mentioned that they have difficulties dealing with Black patients because of language differences.

The image of resources for coloureds and for Blacks in particular being relatively poor both inside and outside the hospital system seems in some cases to reinforce registrars' assumptions and experiences about the discriminatory nature of South African society. Dr 4 was under the mistaken impression that a schizophrenic day centre opened in 1985 by a private non-racial mental health organisation was for whites only, when in fact all races are treated there. Dr 15 claimed to favour sending Mr A from Lumko to Cape Town's drug counselling centre, but could not do so because, as Dr 15 put it, 'I've seen whites and coloureds there but not Blacks.' Dr 15's comment is particularly interesting as a piece in the puzzle of how registrars may unwillingly but nevertheless actively reinforce discrimination. The drug counselling centre in question has since its inception in 1985 been open to all races, but there is no reason to doubt that on a previous visit or visits to the centre Dr 15 did see only white or coloured patients there. Dr 15's immediate assumption seems to have been that Blacks are not treated at the centre. It appears, therefore, that Dr 15 will not refer Black patients there (assuming that Dr 15's talk about caring for Mr A from Lumko accurately predicts this aspect of actual clinical practice). Dr 15 was one of the more experienced registrars, and the rest of our discussion, it should be noted, led me to conclude that this registrar in particular was anything but complacent about the issue of exclusion of services to Blacks. For example, unsolicited, Dr 15 volunteered full support for desegregation of facilities by race, and stated a preference for admitting all patients,

regardless of race, to Spring Valley Hospital if they had drug problems implicated in their conditions. Spring Valley, it will be recalled, is the only hospital with a drug treatment unit. In spite of this, as a result simply of seeing only white and coloured patients at the drug counselling centre, Dr 15 seems unlikely to refer Blacks there.

It seems clear that Dr 15's 'seeing', or vision, is structured in an important way by experience of everyday life in South Africa. The interpretation of not seeing Black people at the drug centre is formulated immediately in terms of discrimination - this seems to be the most compelling discourse. Dr 15's mere perception of discrimination, then, coloured as it is by this discourse, may indeed serve a function in reproducing it for many patients, including, potentially, patients cared for by other clinicians. If Dr 15 is not referring Blacks to the drug counselling centre, other registrars may be less likely to see Blacks there and may in turn be less likely to refer Black patients. This pattern could in turn have implications for the inner dynamics of an organisation like the drug centre. The lower the referral rate of Blacks, potentially, the more the organisation could come to regard itself as primarily geared for whites and coloureds as these are the people who use the facilities more. Black patients and their particular needs (notably that for having staff able to speak their language) could be marginalised through this process. The case I am making here is of course hypothetical, but nevertheless instructive.

One service which seems to be seen to be available to Blacks but not to others is that of the traditional healer. Four registrars mentioned that they expected that Black patients would have consulted traditional healers (Drs 2, 6, 13 and 17) prior to admission, and four (Drs 2, 5, 9, and 16) anticipated that traditional healers would play some part in ongoing care. This was viewed in a number of different ways. Dr 15 seemed to associate the seeking of help from traditional healers with regrettable maintenance of superstitions, and in fact said that if a Black patient were not 'westernised' this would imply a worse prognosis. Dr 16 by contrast laid great store by the importance of fitting treatment to the 'cultural circumstances' (Dr 16's term) of the patient, and saw traditional healers as an important

resource. Dr 9 seemed to take a more pragmatic view, arguing that because services for Blacks are so lacking, reliance on traditional healers may be a useful tactic. Dr 2's opinion seems to lie midway between that of Dr 9 and Dr 16. This range of opinions seems to reflect those in the literature reviewed in Chapter 2.

C. Containment, care and control

In discussing treatment plans for the vignette patients, every registrar used the word 'contain' and/or its derivatives ('containing', 'contained', 'containment'). Frequently (in over three quarters of the time the word was used) it was in conjunction with the word 'need' either explicitly mentioned or implied. Dr 11, for example, saw Mr A from Arderne as 'needing containment', Dr 7 in discussing Mr X from Arderne said that he could go to an open ward but 'might require further containment' in a locked ward. This 'need' for 'containment' was always expressed as a need of the patient, and never as a need of the family or of psychiatric or other agencies. Generally speaking, the need for containment was mentioned without further elaboration. Dr 2, however, in discussing Mr M from Myrddale suggested that it may be possible to manage him as an outpatient but added that 'he may want containment which a lot of people becoming psychotic do'. In similar vein, Dr 7 speculated that Mr M from Lumko, as he appears 'subjectively distressed', may be 'asking for containment'.

Drs 2 and 7 seem to be introducing here a distinction between *needing* containment and *wanting* containment. The need for containment, it appears, may be decided on the patient's behalf but not necessarily with his explicit agreement; wanting containment seems to be defined by the patient. This distinction immediately highlights the question of who really 'needs' the containment - the patient or those around him (including professionals)? So when Dr 15 talks of the question of whether Mr M from Arderne is 'containable at home', and when Dr 4 considers whether Mr A from Myrddale 'can be contained on oral medication' (as opposed to injected depot neuroleptics), they seem to be referring more

explicitly to the concept of containment as, essentially, a weapon against social disruptiveness. Containment of the patient in this sense is probably 'needed' more immediately by people other than the patient.

A particularly interesting feature of the word 'containment' here is that it clearly forms part of the common jargon used by registrars. It is probably directly related to the use of the term in the psychodynamic sense, in which it is said that children, for example, need to be in environments in which their anxieties are contained, and that psychotherapy patients have similar important needs (Winnicott, 1984). Use of the term when incarceration or sedation of patients, often involuntary, is being discussed, immediately links these acts with the image of benign care of the Winnicottian 'good enough mothering' (Winnicott, 1984) type (see also Light, 1980, for a discussion of patients' being described as 'needing to be controlled' in the psychiatric training system he studied). This is in spite of the fact that from certain perspectives the provision of 'containment' could be viewed as potential infringements of patients' rights. Usage of a word such as 'containment' in this regard is clearly not purely local, and its pervasiveness through all the registrars raises interesting questions about implicit discourses of control in psychiatry in general. A discussion of these would unfortunately be beyond the scope of the present dissertation (though worth pursuing in the future).

What is relevant here, however, is the observation that the term 'contain' is used in a directly pejorative sense only twice by registrars, and both of these in relation to the Black side of Eagle's Nest. Dr 13 comments that the care on the Black side of Eagle's Nest is 'containment - very very very basic care'. Dr 13 contrasts this containment with what there should be 'ideally' for Black patients - many more social workers so that they will have time to devote to patients and their families. A second registrar's comments on lack of services are even more illuminating. Dr 9 sees as a major problem the relative lack of facilities for non-psychotic Black patients, and in fact expresses a desire not to see non-psychotic Black

patients in the psychiatric casualty setting as they have to be admitted to units inappropriate for them:

There's no ward where he can at the moment if he's not psychotic - particularly if you're not white - AB⁴ could be available at a push, but he'd end up in a fairly closed, kind of contained environment - controlled environment where in fact he may not need to be there.

Dr 9's use of the word 'controlled' here acts as a self-correction for 'contained', which in itself comes after the word 'closed'. Clearly both Dr 13 and Dr 9 are using the term 'contain' here in the same sense that one might say a prison is designed to 'contain' criminals - to keep them locked up and off the streets. It may be the case that the aspect of their work which makes them like jailers is most clear to them when they are dealing with Blacks and in unpleasant surroundings. It appears that this parallel between imprisonment and hospitalisation can for most of the time be submerged by other discourses, such as that of benign care, for example. It may be forced to the surface when the material realities of imprisonment and hospitalisation are very similar. Medicine and the prison as Foucault (1973a, 1979) has clearly shown both operate to control and regulate social behaviour, and deviance in particular. Part of the function of medicalising discourse is to produce the image of medicine as separate from coercive control (Arney & Bergen, 1984). It is interesting that this project fails (even if minimally) when the function of psychiatry is examined in the context of the care and containment of Blacks in a racist society.

The issue of the relationship between psychiatric care and coercion was discussed explicitly by one registrar in the context of the vignettes, and once again race played a pivotal role. Dr 16 was talking about the third vignette presented to him/her, that of Mr A from Myrdale, and the effects of race on the process of certification. In terms of the South African Mental Health Act of 1973 it is illegal to treat any person without his/her consent. Should the person be both mentally ill, and a danger to him/herself or others, then the person must be certified mentally ill according to a somewhat laborious process. This involves an application to a magistrate, and has built into it the necessity for review of the

decision. In urgent circumstances, the procedure may be streamlined (this is known as an 'urgency'), but the review system and laborious paperwork remain.

Dr 16: [discussing Mr A from Myrdale] I think I have some...uh, um, the difficulties may well be ... this man is paranoid, he's in a manic state, he's psychotic, um, yes, definitely (?). This is the type of person, if he came from Cobusville [a wealthy 'white' suburb]...

LS: Um

Dr 16: ... no, I shouldn't have said that

LS: Oh, now it's too late (laughs)

Dr 16: I mentioned this earlier, about, about, let's be frank, there's much less chance, I think, of danger, of medico-legal comeback of, treating the patient from Lumko against his will by intravenous sedation, than, there is in this patient from Myrdale. And certainly, not, certainly, if somebody with this sort of pathology required intravenous sedation, highly articulate, an educated person, somebody from the Eastern Suburbs [a term generally used to refer to wealthier suburbs to the east of the city - Cobusville falls in the Eastern Suburbs, and Myrdale is sometimes referred to under this rubric, though it is in fact a mixed area economically], upper classes living in the Eastern Suburbs, frankly, I would certify that patient probably more likely to certify the patient from Myrdale or from Cobusville. And as an emergency, as an urgency, he requires sedation.

LS: Because of the implication of (comeback)?

Dr 16: Ja, but I know I should be doing the certification for the patient from Lumko also, but, uh ... this is an uncertain thing. It does worry me, because it's constantly an assault of the patient, and, simply because there is less chance of being, of being sued by the man from Lumko....

LS: Ja...

Dr 16: (And) that is very (simple?) Yes, uh, not interested in (?), it's just that it's much more likely if I'm covering my back. And it comes across as being more concerned for the person from Cobusville, but its more concern for myself. And we face the reality that the white patient has more access to the legal system

LS: (And is more hard?)

Dr 16: I mean, (in psychiatric casualty it) is a (disaster)... to sedate someone intravenously against his will, without having certified the patient

Dr 16 is making it quite clear here that, for him/her (and I suspect for others), part of the comeback against involuntary treatment of patients in the absence of certification lies in the patients' own ascribed social power. White and wealthy patients, then, appear far more

likely to be taken through the complexities of certification, whereas powerless Blacks in particular may be sedated against their will. Informal discussions I have had with staff at Eagle's Nest all support what Dr 16 is saying, and nobody to whom I have spoken denies that this pattern of treating Black patients in particular against their will and in the absence of certification occurs⁵.

I have no direct evidence that this practice in fact does occur in reality, but what is more important for the current discussion is that I do know that it exists as a social reality for Dr 16 and for the other people with whom I have discussed the matter. I make no attempt to condone this apparent practice, but I do wish to make it clear, once again, that to ascribe Dr 16's apparent behaviour simply to moral failing or even to personal racism is to ignore other important factors. Registrars in the psychiatric casualty situation are very busy indeed, as we have seen, and the service is under pressure. Problems communicating with Black patients abound and there is no adequate provision of interpreters. All of this, of course, amounts to gross racism at the institutional level but it is a mistake to assume that for a health system (or any organisation) to function in a racist way all operatives of that system must either in themselves be racist or content to contribute to racist practices. Other information that I have from the interviews leads me to believe that Dr 16 is neither (or, at least, not consciously) racist, nor in the least comfortable with his/her own part in what amounts to selective abuse of patients along race or class lines. Yet I cannot but agree that if Dr 16's self-description is accurate, then Dr 16 is indeed an agent of racism. There may well be an argument for searching in the case of Dr 16 and others for pointers towards racism at an unconscious level. Such a line of research, though fraught with potential dangers as the rather crude studies of Lambley (1980) and van der Spuy and Shamley (1978) have shown, may well be very fruitful. But it is also possible to examine the matter more simply, as I try to here. The mundane exigencies of everyday life in the psychiatric system seem almost to compel behaviour which is, in the end, racist.

My emphasis here on the institutional level recalls the gap in the literature between cultural hermeneutic and critical medical anthropology approaches alluded to by Lazarus (1988). I hope that my analysis shows that by locating the individual clinician (like Dr 16, or even Dr 15, who 'sees' that Blacks are not admitted to a drug counselling centre) in the institutional setting one can come to an understanding able to account both for the clinician's world of meaning and for the reproduction of global social inequality through the daily operation of health services. The distinction between the level of the individual clinician and that of the institution, furthermore, is one that is clearly shared by some registrars quoted earlier - those who differentiate between the physical environment of, say, the Black side of Eagle's Nest, and the quality of clinical care available. The distinction drawn does however contain potential problems. Biomedical discourse at the clinical level does tend to individualise social factors, even if biomedicine as an institution is engaged in social management at a broader level (Arney and Bergen, 1984; Silverman, 1987; Young, 1980). As I argued in my introduction to the discussion of ward-rounds (Part 2) it is an appealing but fallacious view to see the one-to-one medical encounter as the essence of the 'true' world of medical or psychiatric practice. When registrars, therefore, distinguish between the clinical and the institutional level, they are both correct and in danger of bracketing out from the 'true' or 'real' domain of care, the physical environment and the everyday life of the psychiatric ward. It may well be that clinical encounters have privileged status within the overall functioning of the context of care but they do not account for all of it. This of course is a commonplace to modern psychiatry which talks at great length about the therapeutic 'milieu', its strengths and its importance (Katz, 1982). Ironically, perhaps, it may be the case that some registrars need to defocus from the importance psychiatry ascribes to the total environment. This seems necessary so that registrars are able to account for their own and colleagues' function as reproducers of inequality and oppression, through working in discriminatory services. This type of separation between the individual and the social realm is of course by no means a product of medical training and socialisation, but reflects dualisms inherent in the construction of many disciplines, including psychology (Henriques et al, 1984) and medicine (Gordon, 1988), and indeed in

the construction of everyday life (Young, 1980). It is also probably central to the way many privileged people in an unequal society remain comfortable with their position.

Issues of containment, care and control, then, can be seen to illuminate factors not just about registrars' views on the issues as they pertain in a narrow sense to the vignettes, but also about their social embeddedness as privileged South Africans and as medical practitioners - a theme which will be taken up again in later chapters.

III. The prospect of integration of services by race

Every registrar interviewed seemed to view race as an important issue in the provision of psychiatric services in South Africa. Without exception, all who were asked said either that they supported the integration of services by race or that they believed that the current system of separation of patients by race was costly. The response of one of the registrars in this regard was interesting. Dr 15 stated a clear preference for integration of services by race, but expressed the opinion that this would be likely to be a view expressed by a minority of registrars. This could not have been further from the truth, but the fact that the impression was held at all should not be ascribed solely to the registrar's being mistaken. Other factors may be operative, as I hope to show in Chapter 12.

Within the spectrum of this overall agreement at one level, however, interesting differences existed. Dr 8 linked support of hospital integration by race to a rejection of part of the most common defence of segregation, and, indeed, of other discriminatory⁶ practices in South Africa (see, for example, Posel, 1984) - the 'cultural' argument:

Dr 8: I'm sort of a... rather cynical about this whole transcultural movement. To me it's... uh... it fits the system nicely.

LS: How does it work, I mean, just in what you said...

Dr 8: Well, I mean, it's... just to me, you know, we've spent forty years⁷... you know, practising, preaching separatism. Everyone's into groups and colours and...

Chapter 10: Registrars' talk about services

uh... and uh, I think it's been, probably - I mean certainly on a colloquial level - to the detriment of the country, and (...) in psychiatry.

LS: Hm. So in fact...

Dr 8: I would like to see our services fully integrating.

LS: So... like all wards integrated...

Dr 8: Ja, everything integrated...

LS: Ja. Um, some people say that there'll be problems with...

Dr 8: Oh, I'm sure there will be, initially...

LS: Hm.

Dr 8: ... but I mean the problems would be because we... there's been so little mixing, and because we all come from our little separate areas.

Dr 16, by contrast, though supporting the idea of integration in principle, sees the issue of 'culture' as far more substantive:

Dr 16: There's certainly various aspects to it, Leslie. Um... uh, I think there are... I think the [psychiatry] department would be happy to integrate fully, um... it operates under certain restrictions, um, government restrictions⁸. The question has been raised and has been discussed and I know that people feel differently about it, but whether it would be a therapeutic... whether it would be therapeutic for example, to have, for example, a neuroclinic, all of a sudden, therapeutically --- (*word inaudible*) like this...

LS: Hm.

Dr 16: ... fully integrated...

LS: Hm.

Dr 16: ... with... how would one provide for full, cognisance and understanding of cultural differences. It would make it very difficult.

LS: Hm.

Dr 16: Wouldn't it be easier, and perhaps make that official, to have, for example, a purely black, psychotherapeutic unit.

An easy and compelling interpretation of the views of these two registrars could be that Dr 8 is less racist than Dr 16 and that Dr 16 is simply hiding discrimination and prejudice behind a smokescreen of concern about 'culture'. Dr 8 focusses on the political

construction of cultural difference. Dr 16, by contrast, emphasises therapeutic difficulties that may arise as a result of integration. Dr 16's views may indeed be seen as a product of socialisation through forty years of rule by the current regime in South Africa, and through the far longer colonial legacy in this country. The immediate context of local psychiatric services and their recent history is also important here. Until the opening of Spring Valley Hospital a few years ago, Black and coloured patients were mixed together on the black side of Eagle's Nest without any regard to possible 'cultural' differences between them, or even to the fact that the patient groups did not speak the same language as each other. This was shortly before Dr 16 began training in psychiatry but it is common knowledge that Spring Valley is a new hospital. During the time that I worked at Eagle's Nest in the early 1980s, furthermore, there was only one Black patient admitted to the predominantly coloured neuroclinic - Mr B, whose case I have discussed in Chapter 4. I do not have figures available, but conversations with colleagues who worked there prior to the establishment of Spring Valley Hospital, confirm that it was exceptionally rare for Black patients to be admitted to the neuroclinic. A major criterion for admission was ability to speak Afrikaans or English, a skill commonly correlated with education level and social class. It is significant that when Spring Valley Hospital opened, the neuroclinic on the Black side of Eagle's Nest was closed, only to be reopened in 1988, during the course of my study. It is also relevant that Spring Valley Hospital, although exceptionally well-equipped, is clearly a product of the prevailing state policy. It has been built in an area far from De Hoop, Eagle's Nest, and the centre of the city, and in a recently established dormitory suburb for coloureds, some of whom have been moved there under the auspices of the Group Areas Act of 1950. The area, furthermore, has no state general hospital, and the fact that what has been seen as an apartheid psychiatric institution is the major medical facility in the area has angered many residents. Dr 16's very mention of the possible need for separate therapeutic facilities recalls all of these issues, regardless of intention, conscious or otherwise.

This does not however necessarily imply that Dr 16 has the welfare of patients any less at heart than does Dr 8. Indeed, the concerns expressed and implied by Dr 16 about the importance of cultural factors in psychotherapy and the right of all people to culturally congruent psychiatric care would probably be viewed as politically liberal in countries where discrimination on the basis of race is not official policy (Dasen et al, 1989; Kleinman, 1988a; Leff, 1988; Littlewood & Lipsedge, 1989; Marsella & White, 1982; Pedersen et al, 1984). Crudely put, it could be said that Dr 8 is espousing a universalist view and Dr 16 a relativist view, and although the distinction between these two perspectives is by no means rigid (Kleinman, 1988a), it is certainly true that relativism has been presented as potentially more sensitive to the perspectives and needs of patients than universalism (Kleinman, 1977). Each of these positions, as I have discussed in Chapter 4, takes on a particular local meaning, as the disagreement between Drs 8 and 16 once again demonstrates⁹.

An important feature of what Dr 16 says lies in the use of the word *therapeutic*. Dr 16 is arguing in essence that integrated facilities may work to the detriment of maximum therapeutic gain. The concept of therapeutic gain, or, indeed, of what could be termed 'therapeutic', is rooted in fundamental concerns about the welfare of individual people. The issue of integration of facilities by race (or any other variable, for that matter, including gender), by contrast, is primarily a broader social issue which concerns itself with questions of what is best for groups. The distinction I make here may be viewed as tenuous, but is nevertheless crucial. The radical therapy movement of the 1960s (Laing, 1960; Laing & Esterson, 1964; see Ingleby, 1981b for a review) made the point that psychotherapy is concerned *par excellence* with adjustment of individuals to their socially ascribed roles and not with the questioning of those roles, and indeed of the potential pathogenicity of the constrictions of the roles. This line of argument has, of course, been challenged from within dominant psychotherapy and psychiatry (Clare, 1976; Wing, 1978) and the details of the debates on this issue are not germane to the present discussion. What is relevant however is the fact that this type of argument has resurfaced in South

Africa lately in a slightly different form (Anonymous, 1986; Levenstein, 1988; see also Swartz et al, in press, for a discussion of some of the background to this type of argument). Anonymous (1986) exemplifies one of the potential problems with this approach by arguing that oppressed people in South Africa do not need to be helped in the direction of introspection but, instead, 'the oppressed must act [politically]' (p. 82). True though this may be in the general context of oppression and the need for dramatic social change in South Africa, Anonymous (1986) fails to take account of the fact that deciding for oppressed people entering psychotherapy that they need to act as opposed to introspect may be, at worst, oppressive in itself and, at best, completely irrelevant to the situation of some people in a state of emotional distress. 'Acting' without introspection may be simply impossible.

It may be similarly argued (and I myself support this view), that it would be best for oppressed people in South Africa to be treated psychotherapeutically in racially integrated units. There are some fairly simple riders that would follow from such integration. Stigmatised though the mentally ill may be in South Africa, as elsewhere, and regardless of race, I very much doubt that under the present regime the appalling physical conditions on the Black side of Eagle's Nest, for example, would be tolerated for whites. Possible exceptions would be the chronic and geriatric white mentally ill, and the grossly mentally handicapped. All of these are members of groups so stigmatised socially that the fact that they are whites has reduced salience. If whites were admitted to the current Black side, facilities would undoubtedly be upgraded - and this would be to the benefit of the Black patients as well.

The fact of the matter is, though, that in spite of the probability that racial integration would improve the lot of Black patients¹⁰, there are likely to be immediate problems which would indeed affect individual patients. These include problems of language, with staff in integrated wards probably tending to use the language of people from socially dominant groups. There are also likely to be expectations about styles of behaviour and modes of

talking about distress which may indeed, once again, tend to favour patients from dominant groups. Most disturbing of all is the possibility that patients' sense of alienation from dominant groups in the wards (middle class staff and patients, who possibly do not speak the same language as Black patients) could lead both to actual situation-appropriate distress and to patients' being inappropriately labelled as having certain psychological problems. In her study of a racially integrated neurosurgery unit, Miller (1988) describes the case of a Xhosa-speaking boy who caused the staff some distress for being 'depressed' when in fact his only problem, Miller discovered, was that he was lonely and unable to communicate with other patients and staff. His 'depression' was cured when a Xhosa-speaking nursing sister did nothing more than speak to him in Xhosa regularly.

Examined from the perspective of individual patients, therefore, the prospect of integration of facilities does pose some potential problems. Dr 16's concerns in this regard, though they may indubitably be read as a tacit argument for the status quo, cannot be interpreted simply as evidence of racism or potential abuse of patients. Dr 16's concerns, indeed, highlight an issue that needs to be taken seriously at the level of care provision for patients. It would be a disservice to patients to sweep aside Dr 16's comments as not worthy of attention simply because they appear to be ideologically incorrect. In this regard, it is interesting that of all the registrars interviewed, it was Dr 16 (and nobody else) who raised serious concerns about the effects of racism on the initial treatment of patients in the psychiatric casualty setting. Dr 16's comments in this regard, which have been reported on earlier, were entirely unsolicited by me.

If it is not possible to write off Dr 16's discussion of 'therapeutic' issues in hospital integration simply as racism, it is also interesting to examine the responses of a registrar who is clearly deeply concerned about the effects of segregation on patients. The passage that follows was not elicited by my asking about the issue of integration at all. The issue was raised by Dr 17 in response to my very first question covering material other than

identifying data and work history¹¹. I asked Dr 17 what it was like working as a psychiatric registrar, and this was the response:

Dr 17: Its difficult to work in this kind of set up and...

LS: How do you mean, 'its difficult to work in this kind of set up'?

Dr 17: Just the way that the psychiatric and the whole hospital system's...like the outpatients are treated in a separate ward ...and we have a separate hospital in Spring Valley for the coloured patients and that's...

LS: Ja, so you're not satisfied with that?

Dr 17: Of course not.

LS: Ja. You...you...Are you saying that you feel that...um...patients should be integrated?

Dr 17: Hm.

(interruption)

LS: Ja. So you were saying that...that...um... integration of patients... [Dr 17: Hm]. Um...Would you say that the services that are offered at present are unequal or biased?

Dr 17: Um...facilities at Spring Valley are...the wards are much better than this [the white side of Eagle's Nest] admissions ward. So they do a good service. So I can't really say its unequal. Maybe the facilities on the other [Black] side aren't as good as they should be but they are things are looking up.

LS: Hm. But nevertheless, you feel it would provide a better service if they were integrated.

Dr 17: Ja. It would save a lot of money.

LS: Some people say...I mean, one of the arguments against that approach... - I just want to put it to you - um...is that...Well, there are two arguments. The one is that patients from different groups are alienated from each other. What's your response to that?

Dr 17: I think there's (words inaudible) now. I mean, the cultural background has actually got nothing to do with the pattern - they're all psychotic.

[...]

LS: Ja. The other thing that people say is that...um...you know, its a bit unreal because of the society so divided...you must look at the unreality of having a service so integrated. And so that's an argument against it. I'm just interested in your response to these things.

Dr 17: I don't know. Well, only that if people do argue like that, then its arguing for the status quo.

Dr 17's view is clearly that integration must happen and that arguments against integration are no more than political defences of an unacceptable situation. This view is expressed unsolicited and early in the interview and is maintained in the face of the two most common counter-arguments - firstly that patients will be alienated from one another (Dr 16's argument may be seen to be a version of this), and secondly that it will be 'false' to integrate health facilities as there is such pervasive segregation outside of these. Dr 17's comment, however, that 'the cultural background has actually got nothing to do with the pattern - they're all psychotic' is very interesting. Taken out of context (and with great injustice to the intentions of Dr 17) it could be read to mean either:

1. We can integrate the patients by race because, after all, they are only psychotic, and they would not notice if they were integrated

or

2. We can integrate the patients by race because, after all, they are only psychotic, and it would not matter as psychotic people are not deserving of the comfort of differentiated care.

Both these interpretations would, as I have mentioned, be incorrect and unjust. Dr 17's talk, however, does raise the possibility of a view of the label 'psychotic' as defining an outgroup. This outgroup, labelled 'psychotic', is fully defined and characterised by that label to the extent that other socially powerful labels like those of race become subordinate. Being 'psychotic' is what matters. I should mention that the evidence on which I base this strong interpretation is slight, but there does seem to be some indication in the discourse that Dr 17 is using the construct 'psychotic' in what Kelly (1955) would term a preemptive way¹². Use of labels in this fashion typifies a distinctly conservative tendency in psychiatry, one which has been associated with a relative lack of concern for patients' rights and autonomy (Lorber, 1972). A third interpretation of Dr 17's response could have a more pragmatic basis:

3. We can integrate the patients by race because, as they are psychotic, the treatment they receive in the current hospital system is purely medical and not therapeutic, so the argument that the patients' cultural background is important to management is spurious¹³.

This interpretation of Dr 17's views may be both more correct and more charitable. This does not undercut the important possibility however that a registrar may be deeply concerned about the rights of patients insofar as they represent racially oppressed groups but not insofar as they are members of the (racially heterogeneous) class of psychotic people. The distinction I made earlier in discussing Dr 16's position between the broadly social and the 'therapeutic' perspectives is relevant here. One cannot assume that emancipatory views on the position of patients as representatives of a politically oppressed numerical majority will necessarily be accompanied by similar emancipatory ideals about the class 'psychiatric patient'. This potential disjunction has important political implications particularly where the issue of psychiatric patients' rights is concerned. It needs to be recognised that psychiatric patients constitute an oppressed group in their own right (Cohen, 1988), and that it is false to assume that emancipation of black South Africans will necessarily take adequate account of the needs of psychiatric patients.

Clearly, the issue of integration of psychiatric hospital facilities stands at the crossroads of issues of black emancipation and the rights of psychiatric patients. The interface between the two issues was most fully dealt with in the interviews by Dr 1:

LS: What's your view on integrating facilities?

Dr 1: Well, its difficult, because I mean, ideally - idealistically maybe - I'm all for integration. But I sometimes wonder what's the point of integrating health services, in a non-integrated country. The government's not integrated, living conditions aren't integrated at all, you know. [...] Culture's not integrated - not integrated in the sense that we've all just got one culture, type of thing. You know, you have a culture that can accommodate differences. That's not integrated. There's so much else that's not integrated, that this integrated health system is going to stick out like a...like a sore thumb. You know, although, as I say, I'm all for it. But I think, a hell of a else...a lot else needs to be...It's part of a wider process of integration. And maybe we should go in anyway, even though its going to be (*words inaudible*) Because if you sit back and wait for the wider process to get going, ...maybe this is a better approach. So I...I'm keen on integrating health services. One can anticipate there are

going to be problems [...] It would be difficult to script it, but I mean, those difficulties are part and...part of integrating processes, are the facing up to these and try and sort them out. Ultimately the only ideal situation can be complete integration of society.

Dr 1 appears sensitive to the complex issues surrounding the question of integration but feels that these should not deter the process going ahead. Dr 1's discussion lays bare many of the points alluded to above - the tension between the micro and the macro levels, the need to see health service integration in broader context, the issue of fundamental political change, and the definition of culture. It is interesting that whereas Drs 8 and 17 reject usage of the concept of culture (explicitly or otherwise) because of its association with repressive state machinery, and Dr 16 talks of 'cultural issues' apparently reasonably unselfconsciously, Dr 1 is unique in problematising the concept in this context. Further issues concerning registrars' talk about experience of 'race' and 'culture' are discussed below.

IV. Registrars' talk about other issues concerning race and psychiatric services.

A striking if unsurprising common theme runs through the registrars' talk about issues of race and culture in their patients. It seems impossible to separate the experience of working with Black patients from the registrars' experience of working in segregated and at times unsatisfactory facilities, and, indeed, of institutional racism. Because of the salience of issues about race in South Africa, furthermore, it may be assumed that these issues may be associated with some feelings of sensitivity or even vulnerability on the part of some registrars.

This may be coupled with a notable feature of the registrar placement rotation. In his discussion of the socialisation of psychiatric residents in the USA, Light (1980) describes the anxieties and difficulties that they have with their first months in adapting to a new role. Experiences registrars have in their first placements or first year (i.e. the first two placements) of being a registrar may be seen to be times of particular sensitivity for them¹⁴.

Table 10.1 below shows the first and second placements through which registrars in the current study had rotated.

Table 10.1. First and second placements of registrars, ranked by frequency

Placement name	Description of race of patients	Number of registrars placed in unit	
		1st	2nd ^c
Percelia*	Black ^a	5	8
Spring Valley	coloured	5	1
Geriatrics*	white/Black ^b	4	1
Orange Grove*	white	3	3
Forensics*	Black/white ^b	1	1
Frankville (alcohol)	coloured (mainly)	0	3
Psych. casualty (De Hoop)	all	0	1

Notes: ^aPrior to the opening of Spring Valley, both Black and coloured patients were seen on this side of Eagle's Nest Hospital.

^bIn these placements registrars cover more than one (racially segregated) ward. Race groups mentioned first in each case represent the ward within the placement having the greater number of beds.

^cTwo of the registrars spent both their first placements on the Black side of Eagle's Nest (i.e. their entire first year).

*All placements marked with an asterisk are at Eagle's Nest Hospital.

Before attempting any interpretation of placement patterns here, I should make it clear that I am not in any position to comment on the wisdom of the placement pattern from a training or a service point of view. My method does not address these issues, focussing as it does more on questions of doctrinal efficacy than on operational efficacy (Moore & Meyerhof, 1977)¹⁵. It is clear from Table 10.1 however that the initial two placements of registrars do not occur randomly across all possible placements (for a list of all placements, see Appendix B). No registrar, for example, is placed within what is termed a 'therapeutic unit' for the first year. The modal first placements for registrars are Spring Valley and the

Black side of Eagle's Nest. Examination of the raw data for placements (not shown in Table 10.1; see Appendix B) reveals the fact that apart from four registrars, every registrar spent at least six months of the first year in training at either Spring Valley or the Black side of Eagle's Nest, with two spending a year on the Black side of Eagle's Nest, and three a year divided between Spring Valley and Eagle's Nest. The only 'white' first or second placement was that of the white side of Eagle's Nest (six registrars in their first year). Early on in their training, then, registrars are more likely than not to be placed in a black unit, and particularly on the Black side of Eagle's Nest. This is part of their introduction to psychiatry, and, as the case of Dr 6 discussed below shows, may have important implications.

Describing a difficult adjustment to being a psychiatric registrar after having been involved in another branch of medicine for some time, Dr 6 spoke of the first placement on the Black side of Eagle's Nest as 'frightening' not simply because of the exposure to large numbers of psychotic people but also because of the lack of perceived support from superiors. Dr 6 entered psychiatry some years ago and said that at that time, if a psychiatric consultant was placed in charge of a Black psychotic ward this amounted to a form of punishment by the senior staff in the department. My own, more recent, contact with psychiatric consultants who have very definitely chosen to work on the Black side of Eagle's Nest because that is where they see the needs being the greatest and the work the most interesting does not bear out this view¹⁶. More important than the question of whether Dr 6's perception is correct, however, is the fact that such a view is held at all. If the consultant psychiatrist was sent to the Black side of Eagle's Nest as a punishment, then it may be the case that Dr 6 saw him/herself, and, possibly, the patients, as being punished by the experience as well. The link between the asylum and the prison, at some level, is once again being raised. It is important to note that Dr 6's professional experience of Black psychiatric patients is moulded not simply by prior experience of and attitudes towards Black people. Other influences include i) the positions Black patients are made to take up in the hospital system, and ii) Dr 6's own positioning as a new registrar, feeling

unsupported by more senior staff who themselves, it appears to Dr 6, do not wish to be working on the Black side.

The report of Dr 6 may be seen to be an extreme view on the unpleasantness of the work with Black patients and to represent a particularly upsetting experience which may well be affected by Dr 6's own personality. It is by no means without parallels from the reported experiences of other registrars, however. Dr 16, for example, describes having taken a child there over a weekend, and the child's looking at the building and being under the impression that it had recently burned down. Dr 12 took aerosol air freshener to work regularly during this placement so that the environment would be at least marginally more pleasant for staff and patients, with unpleasant odours masked. Dr 13 notes that the physical construction of the ward is such that staff generally speaking are cut off from patients and that patients become 'foreigners' purely by virtue of the architectural arrangements. A number of registrars are reluctant to admit depressed or 'neurotic' patients to the Black side of Eagle's Nest purely because the ward milieu is so unpleasant.

The unpleasant experience of the physical environment in which Black, psychotic people are treated occurs within the context of registrar training. Dr 16 recalls:

It... it just has that, sort of dreary, derelict look about it. Um, I know they're renovating it now. But, uh... that was important, so one came into this ward thinking 'Good heavens, no. We can't... we're going to be here for six months. Come, let's do something, you know. Let's ask for carpets, let's do something. And... a strange sense after about a month or so of... um... resignation. 'I'm just going to be here for six months and then I'm... then I'm out of here'.

For Dr 16, the experience of working on the Black side of Eagle's Nest rapidly became similar to that of 'doing time', recalling the connection between the asylum and the prison alluded to previously. The Black side placement, though interesting to Dr 16 from the case management point of view (as Dr 16 later claims), also fairly rapidly becomes something to be endured and escaped. This is so not necessarily because of the way that Black patients are seen but because of the association between them and poor conditions. Because

registrar training, furthermore, is a difficult time emotionally, as all registrars with whom I spoke agreed, the question of the registrar's own (emotional) 'survival' becomes paramount in difficult situations. One strategy to use when confronted with such a situation is that of viewing it as something which is temporary and to be lived through and then notched up to experience. When Dr 16 says 'I'm just going to be here for six months and then I'm... then I'm out of here', the statement is not so much a rejection of the patients as a strategy for adapting to an aspect of registrar life.

V. Concluding comments

As in the previous chapter, it is clear that registrars' expressed opinions cannot simply be equated with official policies, or, indeed, with their everyday functioning as reproducers of inequalities. The fact that they are involved in such reproduction is undeniable; the observation that some of them consciously feel trapped into behaving in ways which they themselves regret and dislike is not sufficient to explain their behaviour.

Registrars' needs to survive the demands of their training may partly explain the fact that they as a potentially powerful group aware of and opposed to inequalities in facilities do not appear to have made their collective voice heard on the issue in such a way that substantive changes are made. It is my intention neither to condone nor condemn this fact of registrars' (perhaps unhappy and reluctant) participation in and reproduction of services they clearly see as unsatisfactory. I do contend, however, that to understand this phenomenon one must examine the operation of institutional factors into which registrars are inserted regardless of their own views on questions of race, culture and racism and regardless, as well, of their own race classification¹⁷. Chapter 11 indicates a strong structural link between the ways registrars view patients and the ways they see themselves. Chapter 12 examines some of the factors in the professional socialisation of psychiatric registrars which have bearing on the question of registrars' responses to issues of race and 'culture'.

Notes to Chapter 10

1. A few years prior to my interviews with the registrars, various departments at De Hoop Hospital (the general hospital in which Psychiatric Casualty is housed) had, without any formal announcements, begun integrating their units by race. It is not necessary here to enter discussion of the minutiae of how this happened or even of ways in which the concept of integration by race in practice seemed to mean different things to different departments. By the time of my interviews, the issue of hospital integration had been taken up as an issue by the National Medical and Dental Council (NAMDA) - the progressive medical and dental association discussed in Chapter 3. The issue of hospital integration was also under discussion by the ethical standards committee of the Faculty of Medicine of the university concerned. The position of the university as a whole at the time of the study, and as expressed by its principal and vice-chancellor was that segregation by race was ethically unacceptable and that integration must be worked for. At the time of the interviews the major psychiatric facility associated with the university - Eagle's Nest Hospital - was still segregated, and many other units *de facto* segregated. Movement towards integration has subsequently begun.
2. Once again, the tape is not audible here. My recall is that Dr 3 spoke about the family living in Arderne, which is very close to Eagle's Nest Hospital and far from Spring Valley.
3. It is, of course, an empirical question whether more 'community services' would in fact ease the load on inpatient facilities. Addressing this issue is beyond the scope of this dissertation, though it should be noted that there is some evidence from other countries supporting this view (Hansen, 1987). Regardless of the empirical evidence for or against the efficacy of community services, however, it is interesting, however, that community services are seen to be important. Emphasis on 'community care' has recently been shown to be part of a 'persuasive rhetoric' (Potter & Collie, 1989). This rhetoric is not purely South African, but has its particular South African realisation (Thornton & Ramphele, 1988).
4. This is an open 'neuroclinic' ward for whites on the white side of Eagle's Nest. A 'neuroclinic', as the term is used in the hospital system, is an open admission ward offering a variety of therapeutic services such as group and individual therapy, family therapy, art therapy and so on along with medication. Patients generally speaking are classified neurotic or personality disordered, though psychotic patients whose behaviour is not disruptive are also treated in such a setting. A 'neuroclinic' is seen as distinct from a 'therapeutic unit' which caters for non-psychotic patients who are designated 'higher functioning' and has a far stronger emphasis on psychotherapies and less on medication. A neuroclinic for Blacks has been reopened recently, as I have mentioned elsewhere, but Dr 9 feels that it is inadequate to the volume of potential patients.
5. The issue of the effects of race on involuntary hospitalisation rates is not purely local (Littlewood & Lipsedge, 1988, 1989; McGovern & Cope, 1987b; Rosenfield, 1984), but the pattern of what happens here, according to Dr 16, is different in that the legal recourse implicit in involuntary hospitalisation of Blacks seems to be being denied.
6. By using the word 'discriminatory', I am aligning myself with the view that mandatory segregation of services goes hand-in-hand with discrimination, and that 'separate but equal', certainly in the context of psychiatric services in South Africa, and probably in almost every other context, is a myth. Clearly, my views on the issue could have had some influence on the way that I asked questions of registrars and on their responses to me. I am unable to measure this influence, but I did try to pose questions and to accept answers in as open a manner as possible. The fact that the responses I received did differ widely may be some measure of my success, but I cannot know what registrars would have said to someone who approved of segregation, for example.
7. The National Party first came to power in South Africa in 1948, and it is from the onset of that date - the assumption of power of the apartheid party - that Dr 8 dates the forty years.
8. Dr 16 appears to be unaware of the fact, as are, in all probability, most South Africans, that legal opinion is divided on the question of whether there are in fact laws which cover the compulsory

Chapter 10: Registrars' talk about services

segregation of hospitals by race. Some lawyers believe that the phenomenon of separate hospitals is in fact more of a tradition than actual compliance with the letter of the Separate Amenities Act of 1953, for example. The psychiatry department does, however, have to operate its hospitals in accordance with the dictates of the various health departments in the country.

9. As has been seen in the discussion of Dr 9 in the previous chapter, tensions between relativist and universalist viewpoints may be observed in the talk of a single person - making characterological conclusions about reasons for a particular person's taking up either position even less defensible.
10. This probability cannot, unfortunately, be labelled a 'certainty', as subtler influences based on less immediately 'visible' characteristics - such as those of social class - may easily begin to make themselves felt even within a completely racially integrated system - once again to the likely detriment of more Blacks than any others, because of the wealth distribution in this country.
11. An alternative interpretation of Dr 17's initial response to my question is that Dr 17 had decided that the issue of hospital segregation was the main focus of my study, and was keen (consciously or otherwise) to give me the 'correct' or 'desired' answer early on in the interview. Even if this is the case, I have reason to believe from the context of our contact that Dr 17 was indeed deeply concerned about issues of discrimination and segregation.
12. Preemptive construing constitutes use of a construct or label in such a way that it diminishes the importance of lower-order constructs and defines the terrain under discussion.
13. I am grateful to Ann Levett for leading me to this interpretation.
14. This assertion was verified in discussion with a number of registrars. Dr 18, in fact, criticised my interview, saying that I had taken insufficient cognisance of the tremendous emotional vulnerability registrars feel early in their training, and that this vulnerability greatly coloured registrars' experience of becoming psychiatrists.
15. Registrar placements, of course, are not just a matter of policy but are affected as well by particular staff needs at particular times, by resignation of staff, and by the number of registrars entering and leaving training at any given time.
16. It should also be mentioned that the placement still tends to be taken by more junior psychiatric consultants. Some years ago, a psychiatrist working on the Black side of Eagle's Nest told me that the placement was one that psychiatrists in the department, generally speaking, had to go through on their way up the ladder to being in charge of more prestigious units such as, say, the white side of Eagle's Nest or one of the therapeutic units.
17. It is often said in South Africa that we need more Black psychiatrists, and this is doubtless so. To assume however that, by definition, replacing all white psychiatrists or registrars with Black ones will solve problems of discrimination against Black patients is probably incorrect. Many institutional factors affecting registrars have a great deal to do with professional socialisation, regardless of race, and cannot be addressed simply by changing the racial composition of a group of registrars or other professionals.

Chapter 11

Registrars' ranking of vignettes

Table of contents

I.	Introduction	287
II.	Method of analysis	289
III.	Results and discussion	292
	A. Certainty of diagnosis	292
	B. Adequacy of care available	294
	C. Prognosis	296
	D. Personal preference for working with patients	298
	E. Registrars' assessments of their own clinical effectiveness with patients	300
IV.	Concluding comments	302
	Notes	304

Chapter 11

Registrars' ranking of vignettes

I. Introduction

This chapter reports on a small subset of data gleaned during the second interviews with registrars. It will be recalled from Chapter 8 that at the end of the second interview, registrars were asked to rank the vignettes they had read on a number of dimensions. These were:

1. Certainty of diagnosis (from the most to the least certain)
2. Prediction concerning adequacy of psychiatric care likely to be received by the patient (best to worst)
3. Prediction of prognosis (best to worst)
4. Personal preference (from the person the registrar would most like to work with to the least)
5. Personal effectiveness as a clinician (from the person the registrar would probably be most effective with as a clinician to the least)

Tied rankings were permitted. These occurred when a registrar could differentiate one vignette from the other two on a given dimension, but saw the other two as indistinguishable with respect to the dimension in question.

It must be recognised at the outset of this chapter that rankings of the type made in this part of the study necessarily provide somewhat crude data in that all of the dimensions listed above are complex. The areas chosen may suggest to registrars relationships between vignettes which cannot easily be contained in unidimensional rankings. For example, it could be the case that a registrar might view the adequacy of inpatient care for the patient in one vignette as likely to be superior to that available to another patient, but

would anticipate that follow-up services for the second patient would be better than for the first. To force these two dimensions into the single one of 'adequacy of care available' is clearly to lose information. A further drawback of the method is that it loses the complexity of registrars' approach to the questions. For example, a registrar may feel that the prognosis of two hypothetical patients is roughly equal if both have supportive families, but that one patient's prognosis would be seriously compromised in the absence of such family support, whereas the prognosis of the second patient would be minimally affected. The fact that the ranking measures are rather crude was openly discussed with all registrars and they were urged not to undertake any ranking which they felt too constraining or arbitrary to reflect their opinions accurately¹.

The rankings were undertaken, however, in the context of the gathering of large amounts of qualitative data, and cannot be seen as independent of or worthy of interpretation out of the context of that data. The very crudity of the ranking data, furthermore, offers the convenience of summary of information and opens the way to the answering of questions not easily addressed by other means, as we shall see later.

The number of ranking questions had to be kept small because of the time constraints on the data-gathering interviews. In planning the study as a whole I had at one stage considered undertaking more complicated ranking exercise using a repertory grid approach (Kelly, 1955). The size of the grid, however, required to provide meaningful data would have implied even longer contact with registrars, and the plan was abandoned for the current study (though not necessarily for future ones).

All the dimensions chosen enabled me to explore aspects of the question of the relationships between type of symptom profile and race in registrars' 'positioning' (Henriques et al, 1984) of hypothetical patients. From the perspective of dominant universalist psychiatry the symptom profile should override other issues such as race (Kaplan & Sadock, 1988; Wing et al, 1974). I suspected that this would not be the case and

was interested in the interaction between symptom profile and race². Within a five question limit, furthermore, I attempted to sweep through a range of dimensions covering major foci of this dissertation, from the narrowly diagnostic (certainty of diagnosis) to the personal (personal preference to treat).

As in other chapters, discussion is necessarily selective for reasons of space, and I attempt to confine my argument to issues directly germane to the central concerns of the dissertation. The quantitative data presented in this chapter are, however, complete.

II. Method of analysis

For each of the five dimensions, a 9x9 table was drawn up showing relative rankings of the nine vignette possibilities³. Table 11.0 shows the results for the dimension of certainty of diagnosis. Discussion of this matrix will demonstrate the method used.

Table 11.0. Ranking of vignettes on the dimension of certainty of diagnosis

	AA	AL	AM	MA	ML	MM	XA	XL	XM	Total
AA	■				-1	0		2	-3	-2
AL		■		-1		-2	-1		-1	-5
AM			■	-3	0		0	0		-3
MA		1	3	■				3	-2	5
ML	1		0		■		0		0	1
MM	0	2				■	2	2		6
XA		1	0		0	-2	■			-1
XL	-2		0	-3		-2		■		-7
XM	3	1		2	0				■	6

As will be seen from Table 11.0, each column (with the exception of the additional [tenth] column, marked 'Total') has been given a two-letter code, with the same codes being given

to the rows. Each code stands for a particular vignette, with the first code letter indicating whether the vignette was of Mr A, Mr M, or Mr X; and the second letter indicating suburb - Arderne, Lumko, or Myrdale. 'AA' therefore refers to the vignette of Mr A from Arderne, 'ML' to Mr M from Lumko, 'XM' to Mr X from Myrdale, and so on. The numbers within the cells note the summed relative ranking of the two vignettes represented by the row and column defining the particular cell, according to the method to be set out below. Bullet marks (■) are used along the main diagonal to denote cells which are defined by the same vignette by row and by column, and for which there can be no row/column comparison. Empty cells indicate comparisons that were not made by registrars in this study. It will be recalled that registrars received vignettes such that each examined each of the three constructed stories and each of the three suburbs (in differing combinations). It therefore never occurred that the same registrar would compare Mr A from Arderne with Mr M from Arderne, for example; or Mr A from Arderne with Mr A from Lumko. It did happen, however, that three registrars compared Mr M from Arderne with Mr A from Lumko, for example, as these vignettes differed by both text and ascribed suburb.

The method for generating the numbers within the cells can be explained by the following example. To obtain the figure in the cell defined by Row AA and Column ML, all three cases where registrars received that combination of vignettes were explored (Registrars 5, 11, and 17 all received the vignettes AA, ML and XM). Each time an AA vignette was ranked, by one of these registrars, superior to an ML vignette (i.e. each time a registrar said that the diagnosis in the case of Mr A from Arderne was more certain than that in the case of Mr M from Lumko), a score of 1 was recorded. Where AA was ranked by a registrar as inferior to ML on the dimension, a score of -1 was recorded. Tied rankings were given a zero score. The figure that appears in the cell is the sum of the three relative rankings made by the three registrars. In this case, then:

Dr 5 rated Mr A from Arderne as having a less certain diagnosis than Mr M from Lumko, yielding a score of -1.

Chapter 11: Registrars' ranking of vignettes

Dr 11 also rated Mr A from Arderne as having a less certain diagnosis than Mr M from Lumko, yielding a score of -1 .

Dr 17 rated Mr A from Arderne as having a more certain diagnosis than Mr M from Lumko, yielding a score of 1 .

The total score, then, for the cell defined by Row AA and Column ML is $-1-1+1=-1$. This figure is recorded in the cell.

The same method was used to calculate the scores for each cell above the main diagonal, and, in fact, could have been used throughout the table. It was noted however that the table must be symmetrical across the main diagonal except for a change of sign. For example, the cell defined by the Row ML and the Column AA, which indicates the ranking of vignette ML relative to AA must simply reflect the inverse of the ranking of AA relative to ML, a score of $+1$ as opposed to -1 . It was thus possible to fill in all the scores below the main diagonal simply by inspection.

This procedure yielded four scores for each vignette row, as each vignette was compared with a total of four others in the study. AA, for example, was compared with ML, MM, XL and XM - all those vignettes differing from it by both suburb and vignette text. These four scores were added together in each case to yield the figure which appears in the 'Total' column on the right. It should be noted that the maximum possible score for any cell in the body of the table would be 3 - for those cases where the row vignette was consistently ranked superior to the column vignette. The minimum score would be -3 , for consistent inferior ranking. The possible range of scores in the 'Total' column for any vignette, then, would be $[-12, 12]$, ranging from consistent inferior ranking throughout all comparisons to consistent superior ranking throughout.

The figures in the 'Total' column provide a summary of the ranking of any given vignette relative to others, and may be transposed into the matrix shown overleaf in Table 11.1.

Table 11.1. Summary matrix showing total rankings of vignettes on the dimension of certainty of diagnosis

	<i>Mr A</i>	<i>Mr M</i>	<i>Mr X</i>	Row total
<i>Arderne</i>	-2	5	-1	2
<i>Lumko</i>	-5	1	-7	-11
<i>Myrdale</i>	-3	6	6	9
Column total	-10	12	-2	0

$$Range_{suburb} = 20$$

$$Range_{vignette} = 22$$

It will be noted that figures in the cells are simply read off from the 'Total' column in Table 11.0. The row and column totals are generated by addition of cell values, and the range figures appearing below the table are obtained in the following way:

$$Range_{suburb} = \text{Highest row total value} - \text{Lowest row total value, which in this case becomes } 9 - (-11) = 20$$

$$Range_{vignette} = \text{Highest column total value} - \text{Lowest column total value, which in this case becomes } 12 - (-10) = 22.$$

For presentation purposes in the rest of this chapter, only summary matrices will be shown. The original tables from which these were derived can be found in Appendix E⁴.

III. Results and discussion

A. Certainty of diagnosis

Table 11.1 shows that, overall, registrars seem to view the vignettes concerning Mr M as having the most certain diagnoses (column total of 12), those concerning Mr X as taking up

a middle position (-2), and those concerning Mr A to be the least certain. This is not surprising. The vignette for Mr M has the most information (the most symptoms reported). Whereas the Mr A and Mr X vignettes have roughly the same number of symptoms reported, in the case of Mr X these cluster fairly neatly in a schizophrenia/hysteria-type area. Those for Mr A, on the other hand, present a deliberately mixed picture including schizophrenia, mania, and disorientation.

Closer examination of the actual cell profiles, however, reveals an interesting interaction feature. Those cases where Mr X is identified as coming from Arderne or Lumko do not differ appreciably from those of Mr A from Arderne or Lumko. Mr X from Myrdale, however, is dramatically more certain in terms of diagnosis than Mr X from Arderne or Lumko, and shares the highest cell score of 6 with Mr M from Myrdale. Examination of registrars' actual diagnoses of Mr X (Table 9.1 in Chapter 9, p. 223) reveals that all but two of the registrars diagnosing Mr X from Lumko gave multiple diagnoses or the portmanteau 'psychotic diagnosis'. Each of the cases of Mr X from Arderne, however, and Mr X from Myrdale, received four clear diagnoses of schizophreniform psychosis. The registrars talking about Mr X from Arderne, however, were more hesitant in their talk than those discussing Mr X from Myrdale.

A possible interpretation of this finding is that the atypical psychosis features of a story like that of a white Mr X are easily moulded by registrars to fit into a reasonably clear standard diagnostic picture. When Mr X is seen to be coloured, or, even more importantly, Black, however, doubts about the validity about the registrar's own application of standard diagnostic procedures on the basis of limited information become more pressing. In the more standard-type vignette of Mr M, furthermore, there is little to choose between the scores for a white and a coloured Mr M. -Fnce again the 'foreignness' of a Black Mr M leaves its mark. The Mr A vignette is anything but standard, and yields the least variation amongst the race groups.

The range figures quoted below Table 11.1 give a rough indication of the sources of variation in scores amongst the vignettes. It appears in this case that certainty of diagnosis is affected roughly equally by race ($\text{Range}_{\text{suburb}} = 20$) as by vignette text ($\text{Range}_{\text{vignette}} = 22$). Universalist psychiatry would anticipate the structure of the vignette to be the more crucial in this regard; clearly race of the patient is playing an important role here.

B. Adequacy of care available

Table 11.2 shows registrars' relative rankings on the vignettes for their perception of adequacy of care available to patients in the hospital system.

Table 11.2. Summary matrix showing total rankings of vignettes on the adequacy of care available

	<i>Mr A</i>	<i>Mr M</i>	<i>Mr X</i>	Row total
<i>Arderne</i>	2	4	-1	5
<i>Lumko</i>	-7	-6	-10	-23
<i>Myrdale</i>	5	11	2	18
Column total	0	9	-9	0

$$\text{Range}_{\text{suburb}} = 41$$

$$\text{Range}_{\text{vignette}} = 18$$

An interesting feature of the rankings in this section is that rankings are preserved consistently both for suburb and for vignette text. Across all suburbs, it is predicted that Mr M will received more adequate care than Mr A who will in turn receive better care than Mr X. Across all vignette texts, furthermore, it is predicted that the person from Myrdale will receive more adequate care than the one from Arderne, who, in turn, will receive better care than the Lumko patient.

The finding that patients with a probable depressive component to their condition are perceived by registrars as likely to receive the most adequate care is understandable given the fact that such patients, being subjectively distressed, are often easier to handle and more amenable to treatment regimes. It is also the case that of all the vignette texts, that of Mr M seems to conform most closely to a clear diagnostic picture - a feature of the design of the vignettes and borne out by the findings on relative rankings for certainty of diagnosis. Although the pattern is maintained throughout, with little difference between the other two vignettes, it is also clear that there is an interaction between vignette text and race of the patient.

For the Black patient, the difference in rankings by vignette type is small (Mr M has a ranking of -6 which is 4 points above Mr X's ranking of -10). For the coloured patient, the Mr M - Mr X difference has grown to 5 ($4 - [-1]$), and for the white patient the difference is 9 ($11 - 2$). It is important not to over-interpret this finding, but the result is suggestive. It may be the case that, for Black patients in particular, and for coloured patients to a slightly lesser degree, the issue of diagnostic description of the case is less relevant to registrars' prediction about adequacy of services available to the patient than when registrars are considering white patients⁵. This possibility would accord with the observation made in Chapter 9 that there appears to be a relationship between patient race and the attribution of psychological motives or 'internality' on the part of registrars, with white patients being seen in more 'psychological' terms. If Black patients in particular, as was seen in Chapter 9, and coloured patients are seen to be psychologically distressed as a result of global social stressors affecting all Blacks and coloureds, then the nature of their condition becomes less relevant to discussion of adequacy of care available than in the case of whites. The conditions of whites may be viewed as more idiosyncratic in aetiology.

There can be little doubt from the findings summarised in Table 11.2 that registrars as a rule see facilities for white patients (strictly speaking within the confines of the diagnostic pictures offered by the vignettes, but I suspect more broadly) as more adequate than those

for coloureds or for Blacks, who are least well provided for. This is borne out by practically every discussion with every registrar (see Chapter 10). The range of scores generated by suburb differences ($\text{Range}_{\text{suburb}}$), furthermore, is far higher in the case of views on adequacy of services than the range generated by vignette text differences ($\text{Range}_{\text{vignette}}$) - a score of 41 versus 18. The range of 41 for suburb type, furthermore, is, as will be seen, by far the greatest of any of the ranges calculated for any of the ranked dimensions. It can be said with some confidence that, as a group, registrars view the adequacy of care available to patients to be fundamentally and importantly affected by patients' race, and in the direction predictable from patterns of power and privilege in the broader South African society.

C. Prognosis

The category of prognosis is an interesting one as it is a portmanteau. In my discussions with registrars, they all mentioned that prognosis is affected by a number of factors including the nature of the psychiatric illness, the adequacy of services available, and stressors and life changes⁶. The term 'prognosis' was not defined specifically for registrars and they were left to place their own construction on the term. This had the advantage of allowing the registrars to work with a term which had clinical meaning for them. It is, however, true that this to an extent limits the permissibility of grouping the data. I assume here that registrars were thinking of prognosis in broadly similar ways, with some central commonalities⁷. In the absence of having asked them to define their usage of the construct, however, I cannot be completely sure.

The results of the ranking exercise for the dimension of prognosis are shown in Table 11.3.

Table 11.3. Summary matrix showing total rankings of vignettes on prognosis

	<i>Mr A</i>	<i>Mr M</i>	<i>Mr X</i>	Row total
<i>Arderne</i>	-2	1	-6	-7
<i>Lumko</i>	2	-2	-2	-2
<i>Myrdale</i>	3	4	2	9
Column total	3	3	-6	0

$$Range_{suburb} = 16$$

$$Range_{vignette} = 9$$

The general racial pattern of the previous two dimensions reported on - that of whites tending to have a 'better' picture attributed to them than coloureds and coloureds better than Blacks - is not preserved here. Whites are given the best prognosis, which may be related to the attributions about adequacy of care discussed earlier. The prognosis for coloureds, however, is ranked lowest for both Mr A and Mr X, though not for Mr M. This means that Blacks take up an intermediate position between whites and coloureds for prognosis in the vignettes of Mr A and Mr X, but not for Mr M. A possible reason for this is that the atypical diagnostic pictures for both Mr X and Mr A may suggest to registrars the possibility of a brief atypical psychotic reaction in the case of Black patients. Every registrar interviewed mentioned experience of cases of disruptive and apparently floridly psychotic Black patients who settled remarkably quickly and who were discharged soon and not readmitted. It remains an empirical question whether there are in fact more such Black people admitted than others, though I have no reason to suspect that registrars were being dishonest. Regardless of the 'facts' of the matter, however, the image of the difficult-to-understand Black patient who 'miraculously' and inexplicably recovers is a powerful one in the context of the system under study, and fits in well with the notion of the 'discourse of otherness' introduced in Chapter 4.

The range of scores along the vignette text and the suburb axes is lower than on the previously reported dimensions, possibly indicating the difficulty of the task of prognosticating from minimal information. It is possible that registrars were cued differentially to different aspects of the interaction of factors that go into predicting prognosis. Responses may have been more influenced by personal experience of aspects of clinical experience than was the case in rankings made on the previous two dimensions. Examination of registrars' comments on prognosis, even for the vignette of Mr X from Arderne which can be seen to be something of an outlier in Table 11.3, are not very enlightening. Overall, registrars tend to cite the nature of the illness as of prime importance in predicting prognosis, with psychosocial stressors second, but, without further questioning, it is difficult to assess the implicit structures which they may be using.

D. Personal preference for working with patients

This is the first of the two questions dealing with registrars' self assessments, questions which tap an area straddling both that of services available (as discussed in Chapter 10) and of registrars' personal position in the hospital system (to be discussed in Chapter 12). The dimension of personal preference was the only one on which rankings were given by all registrars, so the results shown in Table 11.4 below can be seen to be a summary of views of the entire group. It should be mentioned here that the question of with whom registrars would most like to work - a crude social distance measure of sorts - caused some embarrassment to registrars, some of whom were concerned not to appear racially prejudiced. It may be the case therefore, that the fact of complete data on this dimension alone is attributable in part to registrars' not wishing to appear too sensitive about self-revelation.

Table 11.4. Summary matrix showing total rankings of vignettes on registrars' preference for working with the patients

	<i>Mr A</i>	<i>Mr M</i>	<i>Mr X</i>	Row total
<i>Arderne</i>	3	6	-1	8
<i>Lumko</i>	-2	-4	-6	-12
<i>Myrdale</i>	0	5	-1	4
Column total	1	7	-8	0

$$Range_{suburb} = 20$$

$$Range_{vignette} = 15$$

Table 11.4 shows that Black patients hold a clear position of patients least favoured by registrars, with whites occupying a middle position and coloureds emerging as the most favoured. Tempting though it may be to ascribe registrars' apparent distaste for treating Black patients to racism, the result seems strongly tied in with institutional and social factors. Every registrar mentioned language barriers as making the work with Black patients difficult, and complaints about inadequate interpreter services were common. The physical environment of Black wards was a further probable factor contributing to registrars' preference for working with people other than Blacks. A number of registrars mentioned the problems of working with poor (Black) patients when employment is scarce, grants low, and community services practically non-existent.

Another factor working against the 'purely racism' argument in this context is the finding that coloured, and not white patients, are the most highly ranked by registrars. Choice of those with whom registrars would most like to work, however, does not simply indicate positive feelings registrars may have toward such a person. For example, as is discussed by Dr 16 in Chapter 10, white patients may be associated with greater power for come-back in medico-legal claims. Their families may be seen to be more assertive and to make greater

demands on staff time. This does not imply that such patients in themselves are less valued by registrars than are coloured patients.

The factor of desire for least disruption in the work context may explain the general low rankings given to Mr X who, in the vignette, is described as actively uncooperative. Patients with a depressive component, like Mr M, as has been suggested earlier, may be viewed as least disruptive and fitting most easily into the role carved out for them by the hospital system.

The fact that there is no great disparity between range of scores by suburb and range by vignette text, suggests an approximately equal contribution of race and diagnostic picture to registrars' preference for particular patients. A truly 'colour-blind', non-racial, universal psychiatric system should have produced similar preference scores for treatment of patients from different races, as opposed to the trend observed here.

E. Registrars' assessments of their own clinical effectiveness with patients

The summary for registrars' responses on this dimension appears in Table 11.5.

Table 11.5. Summary matrix showing total rankings of vignettes on registrars' assessments of their own effectiveness in treating patients

	<i>Mr A</i>	<i>Mr M</i>	<i>Mr X</i>	Row total
<i>Arderne</i>	-2	-1	4	1
<i>Lumko</i>	-4	-4	-6	-14
<i>Myrdale</i>	7	6	0	13
Column total	1	1	-2	0

$$Range_{suburb} = 27$$

$$Range_{vignette} = 3$$

A striking feature of the results shown in Table 11.5 is that, whereas the factor of vignette text seems to play a minimal role in registrars' assessment of their own clinical effectiveness ($\text{Range}_{\text{vignette}} = 3$), the patient race seems to be far more important ($\text{Range}_{\text{suburb}} = 27$). Patients with different diagnostic pictures may be more or less liked by registrars, as we have seen in the previous section, but differences in feelings of clinical competence show no clear pattern across the group of registrars. The pattern by race is, as might be expected, that registrars feel they would be most effective with whites, less so with coloureds, and least effective with Blacks.

As far as cell scores themselves are concerned, it is interesting that Mr A and Mr M receive roughly equal scores at each suburb level, but that whereas Mr X from both Lumko and Myrdale receives a lower ranking than for either of the other vignette texts for those suburbs, Mr X from Arderne receives a relatively higher ranking. It is in fact the only ranking in the table for a vignette of a coloured or a Black person which is higher than the lowest for a white. This apparent anomaly can be explained by reference to the fact that the actual vignette XA was considered in the following combinations: XA, AL, MM; and XA, AM, ML. In both these combinations, XA did in fact take up the middle position. The relatively high ranking of the vignette of Mr X from Arderne along the registrars' personal effectiveness dimension, however, is in marked distinction to the low ranking of the same vignette along the dimension of registrars' personal preference.

This distinction underscores the observation that the two dimensions of personal preference and personal effectiveness seem to be tapping different areas. For a registrar to assert that s/he likes to work with a particular type of patient is not the same as saying that s/he believes s/he will be most competent in treating the patient. This observation does not however provide specific data concerning the way that registrars view potentially uncooperative coloured patients with an atypical/ hysterical-type schizophrenia-like

picture. In my discussion of the case of Ms A presented in Chapter 4, I suggested that clinicians' constructions concerning hysteria in black patients merited attention; the current finding bears this out. At this stage, one can only speculate about the possible particular status of coloured patients in this regard. It may be the case, for example, that though disruptive and atypically psychotic (in the sense laid out in the Mr X vignette) coloured patients are viewed as not very pleasant to treat, they are seen to be relatively more straightforward to treat than their disruptiveness might at first suggest. In common South African mythology, as elsewhere, people who are seen to be the products of miscegenation are often regarded as degenerate (Millin, 1924). Putative high alcoholism and drug abuse rates amongst coloured people (see Chapter 2) reinforce this picture. Blacks, though seen to be mysterious and 'other' and difficult to treat, also are ascribed to have 'dignity' associated with their 'traditional culture'. Coloureds may be viewed as unpleasant and undignified but amenable to what Western-trained clinicians have to offer. It is important to stress that the speculations in which I am engaged here move far beyond the data I have collected, but that associations of this type do hold possibilities for foci for further, more disciplined, exploration of these issues.

IV. Concluding comments

The overall picture of registrars' rankings along all five dimensions is not altogether surprising, though there have been some interesting anomalies discussed. Race seems to play a role, and at times by far the major role, in registrars' assessments, with the categories of psychiatric type at times appearing less important. There can be little doubt that this is, at least in part, a product of the fact that services for Blacks in particular - ranging from the number of clinicians able to speak the patients' language to the physical composition of wards in which Blacks are treated - are seen as grossly inferior to those provided for others. The perceptions of differences by race on all dimensions are in keeping with the findings of the previous two chapters, and in fact the tables in this chapter can be seen to function as something of a summary of these observations.

A question discussed at some length in Chapter 3 with reference to South African psychiatrists in general raises its head again with respect to this particular group of registrars. Given their clear perception that services are discriminatory (as has been seen in both this and the previous chapter) and, in addition, their perception of their own relative lack of competence with respect to dealing with Blacks in particular, how and why do registrars continue to reproduce the *status quo*? This question, crucial to any future attempts to transform South African psychiatric practice into a more equitable system, is discussed at more length in the following chapter.

Notes to Chapter 11

1. Drs 1, 2, 3, 4, 6, 9, 11, 12, 13, 14, 15, 16, 17, and 18 all answered all of the ranking questions. Dr 5 objected to the exercise on the grounds that it appeared to be, as Dr 5 put it, 'manipulative', with the results a foregone conclusion - that Blacks are badly treated by registrars. I did not have such an agenda, but accept that Dr 5 may have been reluctant to participate in an exercise which implicitly used ranking by race. Dr 5 answered only the questions concerning certainty of diagnosis and personal preference for treatment. Dr 7 felt there was insufficient information to make a ranking of certainty of diagnosis, as did Dr 8. Dr 8, in addition, felt there was insufficient information on which to prognosticate. Dr 10 was similarly concerned about the paucity of information and ranked the vignettes only with respect to certainty of diagnosis and personal preference for treatment. In summary, the data presented in this chapter are based on responses of the following numbers of registrars:

1. Certainty of diagnosis - 16 registrars
2. Prediction concerning adequacy of psychiatric care likely to be received by the patient - 16 registrars
3. Prediction of prognosis - 15 registrars
4. Personal preference to treat the patient - 18 registrars
5. Personal effectiveness as a clinician - 16 registrars

It should be noted that incomplete data does not affect rankings differentially by suburb or vignette. No two registrars who refused to answer any of the questions had the same vignette/suburb combinations as each other.

2. It should be recalled that by the end of the interviews, at the time of the ranking exercise, all registrars had identified their vignettes along race lines as I had intended.
3. I am indebted to Dr Tim Dunne of the Department of Mathematical Statistics of the University of Cape Town for his suggestions concerning the construction of the matrices presented in this chapter.
4. It should be noted that the matrix presentation is used for ease of discussion only. It is not intended to imply that the results are the product of a complete factorial design.
5. A number of caveats are necessary here. I am interpreting from pooled data and making attributions as though each registrar had had the opportunity to rank all nine vignettes. It also needs to be recalled that vignettes were deliberately designed to tap overlapping conditions and not very different diagnostic entities. Had there been, say, one vignette clearly presenting a schizophreniform picture, one presenting neurotic depression, and another tertiary syphilis, it is possible that a more uniform picture across race groups would have been observed. The numbers with which I am dealing, in addition, are small. The findings are suggestive, however, within the limits of the method.
6. Registrars' formulations on this issue seemed strongly influenced by research being conducted by senior members of the department at the time of this study. The research focussed on multifactorial prediction of relapse in psychiatric illness.
7. I assume, for example, that all registrars would regard readmissions to hospital, social isolation, abuse of drugs, and deteriorating work performance as signs of poor outcome.

Chapter 12

Professional issues in registrar training and their relationship to questions of race

Table of contents

I.	Introduction	306
II.	The training of registrars and their own psychiatrisation	306
III.	Broader issues of individualisation	310
IV.	The individualised registrar and the issue of race	312
V.	Concluding comments	316
	Notes	318

Chapter 12

Professional issues in registrar training and their relationship to questions of race

I. Introduction

In this chapter I relate some factors about registrar training to the question of their discussion of the issues of racism and treatment of patients of different race groups. I make no attempt here to address all the broad issues about the professional socialisation of registrars, as have been dealt with at length by other authors (e.g. Coser, 1979; Light, 1980; McCann, 1983). It is however necessary for me to consider, at what may initially appear greater length than might be expected, some important factors in registrars' talk about themselves and their training. Such a consideration, I hope to show, goes some way to explaining the complex and pivotal role of the registrar as (at times reluctant) reproducer of stereotypes and racist practices¹. The chapter begins with a consideration of some ways in which registrars, through their training, become 'psychiatrised' in a manner not dissimilar to the psychiatric socialisation of patients. I then consider some broader issues of what I term 'individualisation' amongst registrars, as specifically psychiatric socialisation is only one aspect of this process. In the third section, I relate the material of the previous two sections to questions of race and racism in services. The concluding section places the issues raised in this chapter in a broader context.

II. The training of registrars and their own psychiatrisation

The question of the professional socialisation of psychiatric registrars relates to their work with patients in very basic ways. Care of psychiatric patients tends to differ from that of other medical patients in that psychiatric disorder is more commonly seen to encompass the entire personality and, indeed, the entire being, of the patient than is medical disorder². There is a direct parallel here with the way that psychiatric training is seen relative to other

specialist training in medicine. As was said to Light (1980) in his study, 'It's not what you know but who you are that counts [in becoming a psychiatrist].' (p. 23)³. Psychiatric training, furthermore, has been seen to induce 'identity crises' (Yager, 1974).

Psychiatric registrars, like patients (though there are also obviously crucial differences), are both of low status relative to psychiatrists in charge⁴. Training in psychiatry, more explicitly and centrally than in other medical specialties, involves socialisation into particular ways of being as a person - a moral education not dissimilar to an ideal pattern of reeducation of psychiatric patients into economically productive, reasonably conforming members of society⁵. Within the training system under discussion, psychological stages of adaptation to being a psychiatric registrar are commonly discussed similarly to the ways in which predictable stages of psychotherapeutic treatment are spoken of⁶.

Dr 16, for example, in discussing how pleasant the experience of registrarship has been thus far, feels almost superstitious about not having conformed to the norm of becoming depressed some months into the training⁷:

I've been in it, as I say, more than eighteen months now, almost, and I keep checking myself - when am I going to find the boredom or the depression that they say comes at some stage?...When is it going to come? It hasn't come. And maybe it's... I'm running at a hypomanic depression.

The psychiatric registrar works in a field in which things are seldom as they seem, and in which the concept of the unconscious and its defences is central⁸. It is hardly surprising, then, that Dr 16's reaction to his/her own non-conformity with predictable emotional stages of registrar development is that of self-diagnosis. Dr 16's first conclusion is not that the pattern of registrar adjustment to training is either false or, at least, not universal. It is, instead, a self-diagnosis of a possible hypomanic defence. This use of psychiatric labelling is understandable given Dr 16's perception of the process of registrar training as rather mysterious and highly personal, not unlike the process of psychotherapy:

It's the person that makes a difference. I don't know if one can learn to be a psychiatrist. I know at some stage of one's training things seem to gel more, you know, and gel more into... um... I know this from... from feedback that, uh, supervisors... you know, our six months feedback...that supervisors have said that they watch for this and they can see it when it occurs... where the skills seem to gel, you know, in... in the individual and he's more like a psychiatrist...

The eye of the supervisor, in this situation, is similar to the eye of the psychotherapist looking for changes in a patient.

All of the registrars I interviewed used some form of psychological language or psychiatric labelling in referring to themselves with respect to their training. At one level, this observation is banal, as one would expect trainees to use the dominant code in their work environment⁹. At another level, however, the use of such language reveals mechanisms whereby the behaviour of these trainees is regulated and self-regulated. Dr 7, for example, jokingly speaks of psychiatrists' 'unconscious needs for power'; Dr 9 describes his/her own tendency to think about things in a long - term perspective as a 'neurosis', and his/her lack of willingness to 'rock the boat' by questioning authoritarian teaching styles as a 'paranoia'; Dr 1 describes the reaction of psychiatric registrars to general medicine as 'defensive'. A number of registrars, without my having solicited comment on this topic, informed me that they thought that the behaviour of their only colleague to refuse to take part in my study was 'paranoid'. Some of these registrars, and others, described their own concerns about my maintaining confidentiality, similarly, as 'paranoid'. It is clear from these examples that registrars' behaviour is open to being spoken of and interpreted in a psychiatrised way. It may well follow that registrars' initial interpretation of their own or colleagues' deviance from a prescribed role in the training may be that some form of psychopathology is at work. Conformity, then, becomes evidence of mental health, and lack of conformity becomes evidence of psychopathology. Part of the problem for psychiatric registrars (and, indeed, for patients particularly in the psychodynamic-type therapy most prized in the system under discussion) is that the 'adjustment' or 'appropriate behaviour' that is sought is often not made explicit and may appear a rather mysterious and hence elusive goal. Implicit

demands are nevertheless powerful, and what Light (1980, p. 171) has termed 'the myth of structureless socialization' may serve to reinforce uncertainty and to constrain behaviour from any direction which could remotely be open to the interpretation that the registrar is not conforming. This interpretation elides easily into a 'diagnosis' of 'madness' or 'personality disorder' beyond acceptable bounds¹⁰.

Some registrars displayed an acute consciousness of these issues. Dr 7, for example, coined the wry term 'healthy paranoia' to describe an appropriate response for a registrar to being in a system in which trainees are constantly watched and evaluated psychiatrically. Dr 5, more bitterly, spoke of the final qualifying examination in psychiatry as 'magical' in that it immediately provided the psychiatrist with 'a monopoly on truth' and the right to decide that eccentric behaviour is in fact abnormal. According to Dr 5, the status of being a psychiatrist allows one to be 'vicious', 'catty', and 'bitchy' (Dr 5's words), and defines power relationships with registrars always to the advantage of the qualified psychiatrist:

If you are a registrar and you say to the consultant 'I do not agree with your diagnosis', the question's quite simple, 'You haven't got the gift of seeing the truth, so shut up. I have the experience, I am qualified, you're not qualified'¹¹.

The power imbalance of which Dr 5 speaks here is clearly far more widely elaborated than at the simple level of psychiatrists' knowing more than registrars - it extends, according to Dr 5, into the realm of psychiatrists' viewing registrars as in themselves lesser beings.

Dr 5's arguably cynical discussion of the registrar training was definitely atypical of the responses I received. There was however a universal perception of some sort of divide between qualified psychiatrists and trainees. This divide spanned more than just differences in academic knowledge and included differences in what some registrars termed 'personal growth'. All registrars I questioned on this issue (I omitted the question in two cases), furthermore, supported the principle that it is a good idea for registrars to enter personal psychotherapy as part of their training. Many felt that this should not be

compulsory and some said that they themselves had not felt the need for embarking on such a course, but all approved of the principle. The arguments for or against psychotherapy for psychiatric registrars (I myself support the idea) are not germane to the present discussion. It must follow, however, that registrars, who are seen generally speaking to be in need of psychotherapy, become associated with less emotional maturity than qualified psychiatrists, who are not seen as necessarily requiring psychotherapy. The need for psychotherapy, for whatever purpose, immediately associates registrars with the patient role. The status imbalance implicit in this is of particular import in a tight hierarchy like that of the psychiatric hospital system. I do not have data to support or refute the view that qualified psychiatrists in the system believe that registrars should enter psychotherapy or that this is a matter of policy. I am, however, aware of the fact that this is the view of a senior and influential member of the department. The question of registrars' entering psychotherapy, furthermore, is considered of sufficient importance that it appeared as an issue for discussion in a recent professional examination paper for South African psychiatric registrars.

III. Broader issues of individualisation

The issue of psychotherapy for registrars underscores the highly personal nature of the construction of the training and the perception of issues in the light of individual dynamics. This phenomenon of individualisation is of course related to broader issues within psychiatry and other medical and 'helping' professions (Gordon, 1988; Young, 1980; L. Swartz, 1988). It has important implications, furthermore, for how some registrars view issues of power and racism in psychiatry in general. The following discussion is instructive in this regard:

- LS: Ja. Okay. There's another sense of just all this issue of power. Um, there's another sense of we should get... it's spoken about in psychiatry, and that is really in terms of, kind of, medicalisation of... you know, like eccentric people coming to be called ill and the whole of social life becomes psychologised... and... you know, it's, um... sort of... antipsychiatry kind of argument. How do you feel about that?

Dr 8: No, I mean, to be honest with you, I haven't given it that much thought. Um... you know... you know... I would have to read some of the literature, I mean to give fair comment. I'm sure like any other branch of anything, you know, psychiatry's not above criticism...And, um, I'm sure there are a lot of aspects of psychiatry that could certainly be improved....Um, I certainly don't see it as beyond criticism - at all. And I... I mean I think it's very important as a psychiatrist to be continually, you know, reflective on where you're going and what's happening to yourself, and in terms of what's happening to psychiatry.

Dr 8 was one of the more senior registrars with whom I spoke, and his/her apparent naïveté with respect to antipsychiatry arguments is striking, though probably not surprising when considered in the light of lengthy clinical training which tends to focus more on action than on critical thought¹² (cf. Kingsbury, 1987; Lock & Lella, 1986; McCann, 1983). More important for purposes of the current analysis however is Dr 8's immediate response to the possible problem raised by antipsychiatry. With admirable openness Dr 8 concedes that problems may exist and require examination, but the manner of examination is that of the psychiatrist's looking within, and being reflective. This reflectiveness does extend to the level of examining psychiatry as a discipline ('in terms of what's happening to psychiatry'), but what is happening to 'yourself' is mentioned before this. The discussion of the social regulatory function of psychiatry in its broadest sense has rapidly developed into a discussion of how it behoves the individual psychiatrist to look within. Necessary though this looking within may be, the rapid framing of the solution in this way defocusses discussion from other more collective ways of approaching issues of the power of psychiatry, and from the question of whether psychiatry as a discipline should continue to exist in its present form.

It is important for me to recall at this stage that Dr 8 was one of the registrars most vociferously supportive of hospital desegregation and by no means unaware of issues of power in the South African psychiatric context. It is certainly not my intention to cast aspersions on Dr 8's views, but they are interesting for the present discussion because of the individualistic perspective they represent. This perspective can be illustrated further.

Without exception, registrars saw psychiatry as having been delegated the unenviable social task of controlling deviance. None of the registrars raised the possibility of psychiatry as a discipline acting collectively to challenge the construction of that role, except, once again, in specific instances (such as that of labelling as mentally ill as opposed to criminal a man who physically abuses his wife). Three registrars mentioned the forensic psychiatry situation as one in which issues of power are central, as indeed they are. This focus on a particular aspect of psychiatry, correct though it may well be, simultaneously defocusses from broader issues of psychiatry and control.

Four registrars mentioned that they felt that the DSM III and the DSM III-R (APA, 1980, 1987) represented an important curb on the abuse of the power of psychiatry. The argument common to all four was that with specific, clearly defined diagnostic categories, psychiatrists will no longer be able simply, at whim, to diagnose as mentally ill people they do not like or see as odd. This, of course, is true and represents a recognised strength of the DSM III approach to diagnosis. It is however also noteworthy that no registrar raised the important and prominently debated question of the function of the DSM III (and the DSM III-R) as a means psychiatry has adopted to centralise and increase its power precisely through apparently greater scientific rigour (Lock, 1987; cf Bloom, 1988). It appears then that the perceptions of some registrars may lack a broadly political perspective on aspects of the inner workings of psychiatry as a discipline.

IV. The individualised registrar and the issue of race .

Acutely aware of issues of discrimination as the registrars appear to be, they seem to do little collectively that is effectual about the situation. In the previous two sections of this chapter I have demonstrated two mechanisms by which this apparent lack of effective action may be explained. In the first place, registrars may be reluctant to 'rock the boat', as one of them put it. Such 'rocking' may be read as being reflective of their own psychopathology in failing to adjust to the psychiatric system which, after all, has an

important control over the direction of their lives. Secondly, registrars have been socialised into a way of thinking which emphasises introspection and what may be termed 'internal mobilisation'. This may draw attention away from the possibilities of collective mobilisation on political issues. Lang (1982), furthermore, points out that the heavily affective nature of psychiatric work tends to militate against discussion amongst peers on an intellectual or pragmatic level. Emotions are constantly foregrounded, and unpleasant emotions - such as reactions to competitiveness - quickly and self-consciously dealt with and defused. In such a context (and Lang's [1982] description certainly resonates with my experiences with registrars and in rounds), collective mobilisation may be prevented before it begins, because of the emphasis on dealing with the emotions first. This process can be termed a form of medicalisation of the political, but one which affects practitioners' behaviour rather than that of patients, in connection with whom the term 'medicalisation' is more frequently used. In the end, of course, this medicalisation does affect the lives of patients quite dramatically in that it helps to maintain segregated facilities.

The everyday working lives of registrars, even in wards in which physical conditions are clearly far from adequate, probably reinforce this 'internal' attitude. Where wards are overcrowded, turnover rapid, and communication difficult, the needs of individual patients can barely be met by registrars and other staff¹³. The ongoing struggle to do the best by patients leaves little time or energy for mobilisation around political issues. The working day is long, all registrars do overtime (night and weekend duties), and examinations have to be passed. There is, in addition, preparation for classes and ward-rounds, which can be time-consuming. Registrars, furthermore, do not see one another for most of their working lives, except in those cases where two registrars are working in the same unit, and most of their social time at work (for example, tea times, the social side of ward rounds) is spent with members of other professions such as nursing sisters, social workers, occupational therapists and clinical psychologists. This inevitably leads to the reduction of peer cohesion amongst registrars similar to that discussed by Light (1980, pp. 170-171)¹⁴.

I am aware in writing this that I may appear to be acting as an apologist for what may be seen as the registrars' reprehensible lack of effective action on issues of racial discrimination in their system - indeed, for unethical medical conduct. This is not my intention here. The phenomenon of the silence of registrars needs to be examined and understood as part of any analysis of resistance to change in health services in this country. Simply to condemn registrars as morally unworthy does nothing to clear the way forward to structural change. The operation of this process of condemnation, furthermore, is no guarantee that change will occur. Dr 17, for example, condemns colleagues for not taking greater action on sociopolitical issues, arguing that protection of privilege may underly this. At the same time, Dr 17 has not initiated any action, saying, 'I play a very low-key role', and argues that the risks of being 'thrown out' are too great. One may say cynically that Dr 17, in having taken the decision not to be an activist in any way, does not have the right to condemn colleagues. It is far more interesting, however, to ponder the question why Dr 17 feels subjectively so alienated from colleagues, many of whom, at least as far as they have told me, share Dr 17's concerns. It will be recalled that all registrars who were asked the question without exception said they supported integration of patients by race, for example. Most of them declared this support fairly unequivocally. Why, then, have they not simply refused to slot patients into 'racial' categories?

A disheartening potential answer to this question, but one which needs to be taken seriously from a methodological point of view, is that registrars simply told me what they thought I wanted to hear in the interviews, and do not really care about the issue of integration of services¹⁵. As I mentioned earlier in this dissertation, I am known in the psychiatric system I studied as somebody with left-wing views, and it is certainly the case that respondents shape their behaviour to accord with what they view to be the required set of the interviewer (Mishler 1986; Mixon, 1972). Given, furthermore, the prominence of issues concerning hospital desegregation and patient rights in the university at the time of the study, it may be regarded as unsurprising that registrars presented to me what may be seen to be the 'appropriate' or politically correct response at the time. It may also be

possible that I led my respondents with the manner in which I asked my questions. It is difficult for me to assess this, but my questions were always asked in an open-ended way and tape-recordings of the interviews do not seem to indicate any pressure from my side to answer in a particular way. I should add here that I found the responses to my questions surprising and had no particular conscious desire for this pattern to emerge. It is also the case that I elicited more varied responses to other questions on which I also feel strongly - such as the issue of power in psychiatry, and indeed, the direct question of whether South African psychiatry is racist. This tends to suggest that I did not uniformly subtly pressure respondents into providing me with a unified picture. In summary, though the possibility can certainly not be discounted that there may be an element to registrars' responses which makes them artefacts of their being part of my study, the remarkable uniformity of response suggests that there is more to the data than artefact alone.

In recent South African history, doctors have been threatened with dismissal for complaining publicly about the appalling conditions at the major hospital serving Soweto¹⁶. Although doctors constitute a powerful and respected group in South Africa, as elsewhere, fear of being victimised for attempting to improve conditions for Black psychiatric patients cannot be seen as groundless by any means. Such fear would interlock well with the 'healthy paranoia' mentioned earlier by a registrar. It is possible that registrars are simply afraid of tackling the issue of racial discrimination in services, and that this fear operates at a number of interacting levels: fear of being seen to be pathological, fear of victimisation in and possible dismissal from the registrar training, and fear about reprisals from the state. In a society in which the state has the power to wage intimidatory campaigns against doctors who do dare to speak out, and, indeed, to detain and punish people in a range of ways without any trial (Foster et al 1987; Browde, 1988), it may be reasonable to assume that fears about reprisals at the more local institutional level could be intensified.

V. Concluding comments

It should by this stage be clear that my argument for a contextualised understanding of registrars' reproduction of apartheid does not constitute an apology for their actions. Such an understanding, on the contrary, has direct implications for exploring control mechanisms within the context in which registrars operate, and, through modifying these, laying the groundwork for a more open and equitable practice.

The analysis undertaken in this chapter, furthermore, begs an interesting and important question. How precisely one can link theoretically *i*) the intensely personal issue of registrars' silencing themselves and labelling themselves psychiatrically with *ii*) the institutional level of internal control in a department of psychiatry, and, in turn, with *iii*) the broader context of state repression? This is, to some extent, a particular form of the question about control in institutions that I raised in the introduction to Part 2, and I shall return to this issue at a more general level in Part 4. It could be possible, following the tradition of Milgram (1974), to argue that obedience to authority is simply a feature of the human psyche, and that given the correct psychosocial environment, registrars, like anyone else, will simply conform. The work of Mixon (1972) in particular goes some way to suggest that an important feature overlooked in Milgram's work is the active role the 'subject' plays in constructing the situation him/herself. A more compelling approach to dealing with the issue is provided by Lifton (1986) in his study of Nazi doctors. A great strength of Lifton's approach is that he demonstrates the interpenetration of the discourse of National Socialism and medical discourses during the Third Reich. Like medicine, the Reich was concerned with cleanliness, purity, and progress, for example. Through the metaphorical connection between the individual body and the body politic, it became possible to see genocide as a form of the surgical removal of malignancy, and, indeed, to see killing as therapy¹⁷.

In the local context, a useful question to ask is the following: In what ways do discourses of control within the psychiatric system under examination, and specifically insofar as they affect registrars, reproduce, comment on, or undermine those used by the South African state? To address this question adequately one clearly needs to examine control discourses in the psychiatric system. At the time I designed my study I did not seek permission to undertake such an examination, and it would not be ethical of me to reveal my impressions on this issue. I am able to make a more general point, however. One should not underestimate the importance of the leadership within an organisation as a link between that organisation and broader state structures. Since I completed gathering data for this dissertation, for example, there have been significant changes in the upper echelons of the hierarchy of the psychiatry department in question, and the prospect of racial integration of services seems imminent. I have no doubt that had I conducted my study at the time of writing, registrars' responses, and even, possibly, their patterns of mobilisation would have been different.

It does appear to be the case, however, that the fact of the psychiatric registrar's being constructed by the same individualising discourse as that by which patients are constructed has important implications. Political issues, such as that of race in South Africa, inevitably become individualised and personalised, and the focus on the individual patient draws attention away from the broader picture. Even when the broader picture impinges acutely on the consciousness of registrars, action in opposition to structures that mould their lives becomes difficult. This action would furthermore be marginal to the business of coping within those structures - in the short term both for their own survival and for that of their patients. I do not wish to discount the possibility that some registrars are morally not as pure as might be hoped - this must go for practitioners universally. But I hope that I have demonstrated that to seek the cause for their silences and inaction solely in impaired morality is to ignore the important cultural interplay between the state, the institution, and the emotions. In Part 4 I attempt to lay some of the foundations for analysis of such an interplay.

Notes to Chapter 12

1. It could be argued that the personal opinions of registrars, and their 'reluctance' or otherwise to reproduce South African realities, are simply irrelevant to an understanding of their role in the fabric of exploitation in this country. 'From a materialist standpoint, any explanation of discourse in terms of the speaker's personal feelings and motives will tend to mislead' (Macdonnell, 1986, p. 102). It is beyond the scope of this dissertation for me to enter into discussion concerning the merits and demerits of materialist approaches to language, and it is sufficient for me to point out here that though I regard the registrars' own words as crucial to my analysis, the interpretation I place on them is my own. I hope to avoid the pitfalls of both privileged access theories of the emotions and of assuming - rather like the most crude of universalist psychiatrists, ironically - that an external perspective necessarily yields the most accurate information about respondents.
2. The difference between perceptions of psychiatric disorder and those of medical disorder and in particular those of chronic conditions and conditions that may be broadly termed 'psychosomatic' (e.g. duodenal ulcer) or 'life-style related' (e.g. coronary heart disease - see Helman, 1987, 1988) is of course more of degree than of kind. This is the case particularly in view both of the stigma associated with chronic illness and pain (Kleinman, 1988b) and with developments in the medicalisation of social life (Arney & Bergen, 1984). It is however true to say that in general it is psychiatric disorder *par excellence* which labels the entire person as opposed simply to a condition (Ingleby, 1982).
3. In the system under discussion, partially because of the low status of psychiatry relative to other branches of medicine, selection into registrar posts is not stringent and not consistent. Some registrars told me that they had been given a single, fifteen-minute, interview which focussed on their academic and professional record and not on aspects of their personality. Not having gone through a process whereby it is explicitly demonstrated to them what this scrutiny of 'who you are' entails, registrars are sometimes angered and taken by surprise by the manner in which senior staff feel free to comment on their personalities once they have become registrars. Entrance to clinical psychology training at the same university is extremely competitive - up to 100 people, already highly selected into psychology undergraduate and again selected into psychology honours programmes, compete for six or eight places. It is understood that some people even with excellent references and glowing academic records will not be accepted. This leads to the issue of the personal qualities of clinical psychology trainees being made explicit well prior to selection. The selection process, rightly or wrongly, casts an intense focus on these qualities. This leads, in my experience of the course, to a less painful adjustment to being observed for 'who you are' on the part of clinical psychology interns as opposed to the psychiatric registrars in this study. Clinical psychology interns, in addition, do not have to 'undo' previous aspects of medical socialisation into autonomously operating medical practitioners with high ascribed social status. Throughout their previous university education they have been students in a discipline which before the professional training years does not enjoy a high social standing.
4. Light (1980), in his discussion of psychiatric residents in the USA, describes their 'moral career' (pp. 241-258) in terms explicitly similar to those used by Goffman (1961) as regards the moral career of the psychiatric patient. My own fieldwork leads me to concur strongly with Light that the career of a patient and that of a registrar are indeed similar in important respects.
5. Other forms of medical specialisation, and, indeed, professional training in general, all serve to greater or lesser degrees as rites of passage in which the adoption of the social role of those who have completed the process is the goal. Unlike many other disciplines, however, psychiatry, certainly as it is practised in the training system under discussion, tends to have an explicit system by which changes in personal social status for trainees are monitored and shaped.
6. Before I proceed with this argument, I must make it clear that it is not my intention here to question the usefulness of the institutional construction of registrar training in ways similar to psychotherapy. There is much that is potentially comforting about knowing that one's own strong reactions to personally extremely demanding work follow a predictable pattern. My own training in clinical psychology was shaped by just such psychologisation. I remember feeling very relieved indeed, for example, that my reactions of depression and even panic at being thrust into the position of being

Chapter 12: Professional issues and race

responsible for the treatment of large numbers of psychotic people were seen by my teachers as predictable reactions to the situation. At the same time, however, I was conscious of ways in which my reactions were being subtly shaped by a template of what was seen as the typical response to the job. These two sides to training seemed to me then, as they continue to seem, inextricably interlinked.

It is also important to note at this early stage the extent to which psychoanalytic views of organisations and psychiatric training have led to trainees and other staff in institutions internationally being seen as similar to psychotherapy patients (Halleck & Woods, 1962). The notion of countertransference, and its extension into the concept of institutional countertransference is central in this regard (see e.g. Brown, 1980; Shapiro & Carr, 1987). Case conferences or ward-rounds are seen as sites in which it is the task of consultants to uncover unconscious conflicts which block effective patient care. The notion that psychotherapy training and supervision parallels psychotherapy itself is prized by some of psychoanalytic orientation (Sachs & Shapiro, 1976).

7. There is evidence in the texts quoted earlier to suggest that psychiatric training is indeed associated with an increase in depressive symptoms. If psychiatric specialisation is compared with specialisation in other fields of medicine, however, rates of depression amongst trainees, although close to the top, are not the highest (Hsu & Marshall, 1987).
8. This of course need not necessarily be the case, for example, in a training system working on entirely behaviourist lines. It is definitely so, however, for the system under study, being, as it is, heavily influenced by psychodynamic theory. The same holds for the systems explored by Coser (1979) and Light (1980).
9. Psychiatric and psychoanalytic language, furthermore, has become general currency in a heavily psychiatrised society (cf Castel et al, 1982; Lasch, 1979; Herzlich & Pierret, 1984). It should become clear, however, that this language continues to play a particular social regulatory function in this psychiatric system over and above the function it may play in society at large.
10. This topic has interesting implications far beyond my current aims and I am unable to give it adequate attention here. It is not irrelevant to the present discussion to note however that the very fact that psychiatrists in the system recognise that the difference between sanity and madness is a matter of degree and convention rather than kind may have some unfortunate consequences. One of these may be to allow the label of 'mad' or the particularly pejorative label of 'personality disordered' (Lewis & Appleby, 1988) to be used unpredictably and according to contexts and conflicts in which registrars find themselves. It should also be noted that terms such as 'paranoid', which are in common social parlance, can easily have particular salience in the setting in which registrars find themselves. I very much doubt, for example, that the 'paranoia' of surgeons to which Cassell (1987) refers is identical to the 'paranoia' spoken of by the registrars I interviewed. The precise relationships between different usages of such terms is a matter for further study.
11. To greater or lesser degrees, of course, this type of attitude is common to all professional training (Abbott, 1988).
12. Dr 11, it will be recalled, in response to my questions, said, 'In [Psychiatric Casualty], we don't think, we just do!' This statement may possibly broaden to one about the training more generally, pressured as it is with heavy patient loads and high turnover.
13. This is a view expressed by a number of registrars, as their responses to the vignette study discussed in previous chapters demonstrate.
14. This is potentially exacerbated by the fact that registrars in the system I have studied enter the training in different months and through different placements from the beginning, so that their initial experiences of psychiatry are separate from other registrars' experiences.
15. The term 'care' is of course a loaded one and in need of elaboration. It is perfectly possible, for example, as a transient trainee in a system, to 'care' about an ongoing issue concerning patients, but not

Chapter 12: Professional issues and race

to have any real emotional investment in seeing the problem solved as it will make no appreciable difference to the trainee's life. It could even be the case that registrars who 'care' about the issue would be keen to see changes but not during their period of training in the system as all changes bring with them initial extra work and disruption.

16. In September 1987 101 members of the Department of Medicine at the University of the Witwatersrand, Johannesburg sent a letter to the *South African Medical Journal* (72, September) about the poor conditions at Baragwanath Hospital. The Hospital Services Department of the Transvaal Provincial Administration asked the doctors to apologise or resign. A number of the doctors refused to do so, and the issue received considerable media coverage. The Transvaal Provincial Administration was forced to modify its threat of dismissal simply to a reprimand, but not before a group of doctors had been pressured into signing an apology written by the Transvaal Provincial Administration. This letter, without the permission of the doctors concerned, was published in the *South African Medical Journal* (72, 22 April 1988). An interesting feature of the entire scandal for purposes of this dissertation is that the Transvaal Director of Hospital Services, Dr D Kritzinger, implicitly defended the fact that there were very many patients who had to sleep on the floor at Baragwanath by saying that the hospital served a third world community who were accustomed to sleeping on the floor (SAIRR, 1988, pp. 801-3). The 'third world' argument, as it is often used in South Africa (and clearly so in this context), can mask or provide spurious justification for unequal care provision - in precisely the same way that arguments about 'culture' may be used (Sharp, 1988b).
17. See also Sheper-Hughes and Lock (1987) for further discussion of links between the personal body and the body politic.

PART 4

CONCLUSION AND POSTSCRIPT

Chapter	Title	Page
13	Conclusion	321
14	The state, resistance, and the emotions in South Africa: notes towards a theory	342

Chapter 13

Conclusion

Table of contents

I.	Issues arising from the dissertation	322
II.	Current and future issues for mobilisation in South African psychiatry	328
III.	Summary and concluding comments	337
	Notes	341

Chapter 13

Conclusion

I. Issues arising from the dissertation

This dissertation has explored a range of themes relevant to an understanding of the way that cultural concepts are produced, used, and reproduced in South African psychiatry. Particular focus has been on the practice of certain clinicians attached to a department of psychiatry of a liberal South African university. I make no claim that the empirical data collected necessarily represents the full range of psychiatric practice in South Africa. There is, in fact, a possibility that findings would have been different had different sectors of the same department been studied. The emphasis throughout, however, has been on obtaining data of the best possible quality and on making as full use of context as possible. This has necessitated what in some research traditions would be viewed as the focus on a relatively small canvas. The relationship between this canvas and other South African pictures is a matter for further research.

Like the society of which it is to some extent a product, and to the social regulation of which it contributes, South African psychiatry is beleaguered at present. There are two poles of potential response to this, each of which is compelling, though for very different reasons. The first of these is to leap to the defence of South African psychiatry, and to claim that everything, if not altogether well, is far better than is often made out, and that attacks on South African psychiatry are unfair and, possibly, unnecessary (see, for example Gillis, 1977, 1978; Hemphill, 1989). The second is to portray South African psychiatrists as uniformly immoral and unethical in their reproduction of apartheid (Dommissie, 1986). Each of these responses - corresponding to the 'embattled' versus the 'condemnatory' positions outlined in Chapter 3 - has been attractive to me in different ways. Each is

unsatisfying, however. In the discussion which follows I move back and forth between the poles in a manner designed deliberately to highlight the intricacy of the issues and the inherent contradictions in the subject matter¹.

I am concerned about mental health issues in South Africa, and intensely critical of the disparities in care. It would be comfortable (not to mention fashionable in the international academic context) for me simply to state that South African psychiatry is racist and is in need of radical change. This is true, but is so totalistic a statement that it has very little bearing on the actual day-to-day experiences of South African clinicians and patients. Much of the structure of South African psychiatry, as I hope I have shown, is a product of psychiatry internationally with all its biases along class, race and gender lines (Ingleby, 1981b; Littlewood & Lipsedge, 1989; Loring & Powell, 1988; Mercer, 1986; Miller & Rose 1986). If South African psychiatry needs to be changed, which it clearly does, then part of the need for that change can be located within the discipline of psychiatry itself (Kleinman, 1988a). If by some happy fortune South Africa were changed into a non-racial democracy overnight, and even if, furthermore, more or even all clinicians in psychiatry were to be black, there is no guarantee that this would positively affect the situation of those South Africans labelled mentally ill. It would be ludicrously naïve to assert that apartheid causes all psychopathology in South Africa and that to remove apartheid would be to remove all mental pain and suffering (Swartz et al, in press; Turton, 1986b; Vogelmann, 1986). There may even be, ironically, some positive spin-offs for some black psychiatric patients of the current regime. Reading of the appalling neglect of psychiatric patients internationally as documented by Cohen (1988), I was repeatedly struck by the fact that within the confines of the hospital system I studied, and in its community services, the black patients did not belong in the 'forgotten millions' category. Far from it - they were 'remembered' and scrutinised constantly. They were patients in a supposedly liberal South African institution, under the aegis of a psychiatry department only too aware of the

negative image South African psychiatry has internationally. This alone probably ensured that clinicians, however racist they might be personally, tried not to do anything which could be seen as racist.

This fact of black patients' being 'remembered' and scrutinised partly as a response to international pressure on South African psychiatry can of course be read in another, rather more sinister way. In Foucaultian and post-Foucaultian theory, a major function of discourse and ideology is not to create silences but to manage society through the creation of speech. Knowledge, however detailed, and indeed, however humane at a certain level, functions as a source of power over others (Henriques et al, 1984; Hutton, 1988). Much of the humanist concern about the welfare of black patients in South Africa can be understood in this context.

Sitting in ward-round after ward-round in the hospital system, however, and speaking with the psychiatric registrars and listening to the audiotapes I had made, I was repeatedly struck by the depth of concern for the welfare of black patients. In reviewing the literature as I did in Part 1 of the dissertation, I was able to maintain an emotional distance from most of the authors and to speak about the production of psychiatric knowledge as a macrosocial process rather than as a product of individuals. Becoming involved with clinicians in the way that I did for purposes of collecting data interfered with my ability to keep an emotional distance. To some, this could be seen as a weakness of my approach, but I am confident that the fact of my involvement cued me to aspects of the situation I would not otherwise have seen. It is perfectly possible, for example, to sit on the periphery of a ward-round and to ascribe all that happens to racism or to the malevolent power of psychiatry. As Littlewood (in press) has recently suggested, however, the search for evidence simply that psychiatrists or other clinicians exert power over their patients is

unidimensional and ultimately of little value². Something much more complex is going on, something which cannot be captured by simple formulations.

In this regard, among the many collections of images I carry with me from the research reported here is one which exemplifies the extent to which contradictions can be detected in the system I studied. Week after week I would sit at ward-rounds on the Black side of Eagle's Nest amazed at participants' apparent blindness to the racist overtones of the Robinson Crusoe poster I described in Chapter 7. I arranged with one of the registrars working on the Black side of Eagle's Nest at the time of the interview section of my data-gathering to meet at this registrar's office in the ward below that where rounds usually took place. I arrived a few minutes early and was offered a cup of coffee by the consultant psychiatrist whose office was adjacent to that of the registrar in question. On the wall of the psychiatrist's office was a copy of the Freedom Charter³. A wall of the registrar's office displayed a calendar disseminated by a militant anti-state black trade union. Both the registrar (whose stay on the ward was temporary) and the consultant (who was a permanent staff member) had chosen to display in their offices overtly anti-government material (display of the calendar was possibly illegal)⁴. Yet these were the same people who sat in rounds under a racist Robinson Crusoe poster, and who were engaged in providing care in a crumbling, damp, overcrowded set of wards far inferior to the magnificent accommodation on the white side - accommodation they drove past probably every working day of their lives.

The contradictions of the position of this particular registrar and consultant certainly merit further exploration, but I am using their case here purely for illustrative purposes. They were people engaged in the simultaneous subversion of and perpetuation of the current South African social order. On the one hand, there is no doubt that each played a role in maintaining segregated and unequal services; on the other it is equally clear that both were

engaged at the overt ideological level, at least, in the struggle for the overthrow of the current regime.

What can be said of a professional culture which admits of such contradictions? In one sense, it can be said simply to exemplify aspects of social life in general. According to recent approaches to social theory, the notion that 'society' is an integrated whole free from contradiction needs to be deconstructed, and the possibility for contradictory narratives allowed (Henriques et al, 1984). The issue of contradiction must be dealt with more specifically and contextually, however.

Part of the context must be found, once again, in the inherent contradictions typifying medical discourses. On the one hand, the clinician is assigned the role of caring for human welfare; on the other, the reality of the medical institution and of medical bureaucracy in general requires the clinician to process people in a technocratic manner (Coser, 1979; Light, 1980) - amongst other things, to 'get rid of patients' (Mizrahi, 1987). The realisation of this contradiction in the particular situation I have studied can best be illustrated by recall of another incident that occurred during my data-gathering.

Early on during my period of attendance at ward-rounds in Psychiatric Casualty at De Hoop, I sat in on a few interviews with patients so that I could have a contextual understanding of ward-round process. On one occasion, a registrar was attempting to assess whether a Black man was psychotic. The registrar could not speak Xhosa and the patient could not speak English, and in the absence of a hospital interpreter, the registrar resorted to the common practice of asking a relative of the patient to interpret. It rapidly became clear that though the relative had some English, it was difficult for him to follow the registrar's questions. The registrar therefore called one of the cleaning staff into the room and, with her present, developed a *modus operandi*. He asked the cleaner to

translate each of his questions to the relative, who then put the question to the patient. The patient then responded to the relative, who then spoke to the cleaner, who gave a version of what had transpired to the registrar in English. The registrar was then able to make notes in the folder, and to ask the next question. It was initially not entirely clear to me why the relative's participation in this chain was now necessary, as the cleaner was able to converse directly with the patient in Xhosa. It appeared to be the case however that the registrar, having invited the relative into the session, did not wish to cause offence by implying that the relative was not helpful to the proceedings, and, even worse, by banishing the relative from the room.

We sat, then, the five of us in that office (supposedly the site of private and confidential dyadic talk between clinician and patient), with me somewhat on the periphery, and the interview proceeded as smoothly as was possible under the circumstances. During the course of the mental status examination, the registrar began an assessment of the patient's orientation for time, place, and person. The patient accurately identified the month and the fact that he was at De Hoop Hospital. The registrar then asked the cleaner to ask the relative to ask the patient who he (the registrar) was⁵. The reply came back through the interpreters that the patient had identified the registrar as a secretary. Somewhat wryly, the registrar remarked that the patient had accurately captured the essence of the registrar role.

This story, amongst many other things I shall not go into here, illustrates the fact that clinicians act simultaneously as persons concerned with care, and as bureaucrats managing social life (Arney & Bergen, 1984). Attempts on the part of white clinicians to understand Black patients better through, for example, use of interpreters, may, ironically, contribute to patients' being positioned as relatively faceless ciphers in a vast, barely comprehensible system.

The fact that this paradoxical process of effacement of identity is not by any means purely a South African phenomenon⁶ does not condone or excuse South African psychiatrists. In South Africa, on the contrary, the production of identity is a central political issue and cannot be ignored (Du Preez, 1979). Clinicians, like their patients, are inserted into an environment in which the struggle for definition of personal and group identities is particularly intense; it is up to clinicians either to reproduce mythologies or to subvert them. The difficulty, on the other hand, as I have shown, is that subversion of identities created in a racist fashion is often accompanied, paradoxically, by simultaneous reproduction of identities.

What does this imply for the current and future status of clinical psychiatric practice and knowledge production in South Africa? I have shown in this dissertation how the local transcultural psychiatry literature creates, in the main, knowledge which fits comfortably with apartheid ideology. Clinicians, even at a 'liberal' institution, and regardless of their own status as black or white South Africans, are often engaged in perpetuation of the *status quo*. In the next section of this chapter I shall consider some of the implications of this fact for future action in the sphere of South African psychiatry.

II. Current and future issues for mobilisation in South African psychiatry

Writing a dissertation during a period of dramatic social upheaval and change has both benefits and costs. Five years ago, when I was writing the articles on which some of the earlier chapters of this dissertation are based (Swartz, 1986c; 1987b), I should not have predicted that at the time the dissertation was being finalised, organised psychiatry, as represented by the Society of Psychiatrists of South Africa, would be on the point of issuing a clear anti-apartheid statement for the first time (Allwood, personal communication; see

Chapter 3). This is a potentially exciting development, and time will tell whether more substantive changes will follow. From a theoretical perspective relevant to my argument, an important lesson from this change, should it indeed occur beyond the level of rhetoric, is that professional psychiatric culture is dynamic and changing. If much of South African transcultural psychiatry falls prey to a reificatory ahistorical approach to the concept of culture, how much more so should any work attempting to explore the shortcomings of the approach be aware of the dynamic nature of the culture of South African psychiatry itself. Works such as that of Dommissie (1986) and Lambley (1980), important though such interventions have been historically, now read to those conversant with everyday psychiatric practice in South Africa as anachronisms. The racism of South African psychiatry, like that of the sophisticated apartheid state (Posel, 1984), may be ever-present, but couched in legitimacy structures which are far from crude. Many South African clinicians in the field of psychiatry, furthermore, are simply not rabid racists in any overt sense.

To equate professed anti-racism with humane psychiatric practice, on the other hand, is not necessarily justified, as I suggested in Chapter 10. The issue can be further illustrated by analogy with findings from a recent study of psychologists in South Africa. Lazarus (1988) found that the overwhelming majority supported the idea that there needs to be a greater emphasis on community psychology in South Africa. What does this mean? To some it implies greater support by psychologists of political resistance movements such as the African National Congress, the United Democratic Front and other such organisations; to others it implies working to build and strengthen separate communities along the lines dictated by apartheid policy. Clearly, Lazarus's finding of remarkable uniformity amongst South African psychologists on the community psychology issue does not necessarily indicate ideological uniformity. All that it may mean is that psychologists of various persuasions talk in similar ways as far as this issue is concerned - their actions and commitment may vary greatly. As far as the issue of racism is concerned, it is important to

note that, except in white South African politics far to the right of the current regime (and rarely even then), nobody in this country would admit to being anything other than an anti-racist concerned with equal political rights for all. Propaganda is issued regularly by the state claiming that it is striving towards an equitable dispensation for all.

Requiring that psychiatrists and other clinicians simply assert that they are not racists is clearly no guarantee that a truly equitable psychiatry will emerge. It is unfortunately not the case, either, that clinicians currently engaged in the provision of alternative services and active in what are known as 'progressive' anti-apartheid organisations necessarily hold the blueprint for the development of this psychiatry. The issue of culture in South Africa, as we have seen, is highly ideologised. A major thrust in progressive social theory in South Africa, in the 1970s and early 1980s in particular, has been to replace the concept of racial discrimination with that of class oppression as a primary explanatory model for theorising about the source of power of the apartheid state (Lipton, 1985; O' Meara, 1983; Posel, 1983). In the light of these factors it is perhaps not surprising that progressive theorists in the mental health field have tended to be silent or even obfuscatory on the issues of culture and race as they would affect integrated mental health services in a non-racial democratic South Africa (Dawes, 1985; Vogelmann, 1986; *Psychology in Society*, 1983). The most detailed attention devoted to the culture issue in these circles has, significantly, been in the form of debunking of reificatory and clearly racist usage of concepts of culture and racial difference (Hayes & Nzimande, 1984; Nell & Seedat, 1989; Nzimande, 1984) - some of my own work and work on which I have collaborated falls into this category (Swartz, 1985b; Swartz & Foster, 1984). A second thrust to this tendency can be seen in the work of Turton (1986a) who discussed the failure of a Rogerian-type psychotherapy centre for Blacks by reference to the 'cultural encapsulation' of the therapists.

When I embarked on the field-work section of this dissertation, I was reasonably confident that debunking the implicit racism of much transcultural psychiatry and attempting to guard against 'cultural encapsulation' would go a long way to laying foundations for a more appropriate South African psychiatry. I did, however, have a nagging unease that to be involved primarily in debunking was not a positive basis for future developments. My involvement in ward-rounds and in discussions with and observations of registrars and others soon convinced me that the issues of race and culture in psychiatric patients could not simply be decided away on the grounds of their being morally or politically unacceptable. I remain convinced that it is essential to bear in mind the fact that 'magical thinking', for example, is clearly not the sole province of the 'primitive' (Shweder, 1977), and that people, regardless of skin colour, background, or socioeconomic position, make use of a variety of healing systems, formal and informal (Boonzaier, 1985; Helman, 1984; Kleinman, 1980). The voluntarist idea that the exceptionally poor and disadvantaged people who form the bulk of the Black mentally ill in this country (and certainly in the system I studied) simply choose 'traditional' therapies because they accord with their 'world-view' (Hammond-Tooke, 1975; Schoeman, 1988) is manifestly false, and potentially dangerous. Apartheid psychiatry clearly and unequivocally discriminates on the basis of race, and many 'cultural' arguments may be read as little more than politically legitimacy. All of this is true, and, given the power of dominant state discourse, needs to be reiterated frequently. What is also important to recognise is that this does not dispose of cultural and racial issues altogether.

Many patients do for example believe in the power of the ancestral shades, or make use of explanatory models surrounding spirit possession and bewitchment. Some clinicians in the system I studied were (correctly, I believe) able to view these beliefs as particular examples of universal non-rationality in response to distress and confusion. Even these clinicians, however, were unable to relate to such patients without the issue of the experience of

difference in belief intruding. There may be many explanations for this experience of difference, including *i*) socialisation in a divided society which constructs the idea of difference at every level, *ii*) difficulty in communicating in the absence of a common language, and *iii*) the association I have shown between Black patients and physical provision of care and facilities so unpleasant as to make clinicians emphasise their differentness from such patients. The experience of discord, furthermore, does not disappear in the case of Black clinicians who, as dominant ideology would have it, are culturally identical to the patients under discussion (albeit in watered-down 'westernised', 'urbanised' form). The perception of difference, or even, if the term 'difference' is too restrictive, the experience of unease is an important clinical reality which cannot be wished away because it is ideologically unacceptable or even theoretically poorly conceived.

Some local anthropologists, as was shown in Chapter 4, have pointed out the socially constructed and historically specific nature of many received notions about 'culture', 'race', 'tradition', the supposedly dual first world/ third world nature of South Africa and other dualist notions (Boonzaier & Sharp, 1988; Sharp, 1980, 1981, 1988b; West & Boonzaier, 1989). There can be no doubt of the importance of these insights for future developments in progressive mental health care provision. It is equally important, however, for a discipline concerned with promoting the welfare of (admittedly) ideologically constructed people to recognise that the experience of living in a dualist world, however theoretically and politically unfortunate this experience may be, is a powerful reality. Thornton's (1988) generally exceptionally clearly-argued discussion of the question of the definition and use of the term 'culture', as discussed in Chapter 4, also depends in part on a witty but unfortunate use of bathos in defence of the view that the idea of separate cultures is itself culturally constructed. Thornton is correct in asserting that the belief in cultural separateness is in itself a cultural product, but his comment that people of supposedly different cultures eat the same corn-flakes is not helpful to those concerned with building

an equitable mental health service. The trivialising aspect of the 'corn-flakes' comment has the potential, at best, to induce feelings of guilt in those who experience patients as very different. As I have implied in Chapter 4, the argument takes inadequate account of psychological realities, however (once again) ideologically or theoretically unsatisfactory those realities may be⁷.

I am arguing here not simply against confusing the issue of culture with broader questions of ideology. I am suggesting instead that engagement with rather than rejection of the construction of cultural difference is essential for developments in South African practice. Subject to methodological limitations though the results of the registrars' ranking exercise reported in Chapter 11 may be, the findings in their sheer uniformity are highly suggestive. I know the group of registrars with whom I worked to be in the main politically liberal and well-intentioned. A strong impression created by the ranking exercise and by the qualitative data is that these registrars find working with Blacks difficult, that they do not choose to work with them, and that there is considerable confusion and frustration in such work. I cannot simply ascribe the problems registrars seem to experience to theoretical naïveté, lack of political sophistication, or even misguided adherence to, say, a non-socialist vision for South Africa. I could certainly not conclude, were I to have done only this, that something useful (theoretically or practically) had been said about South African psychiatry. Registrars' perceptions of cultural difference and their experiences of being unable to care adequately for Black patients cannot be consigned simply to a scrap-heap of 'false consciousness' or whatever other term one wishes to use. Neither can all the potentially clinically unhelpful factors of their professional socialisation be simply rejected and wished away.

It is at this point that the connection between registrars' professional culture and the supposed 'otherness' of many of their patients becomes crucial. If a dualist theoretical

perspective is unacceptable, especially in a divided society, then it is surely necessary to develop ways of talking about and intervening in South African psychiatry which takes simultaneous account of the culturally constructed nature of the 'patient' (black or otherwise), and the culturally constructed nature of the clinician (black or otherwise, once again). This is a daunting agenda, and one to which I cannot possibly do full justice here, but an important one. It requires an informed relationship between psychiatry and the social sciences (Kleinman, 1988a), especially as they have bearing on the South African situation, in such a manner that the methodological contribution of these approaches is not transformed into a series of biomedical-type 'facts' to be learned along with, say, the Schneiderian symptoms of schizophrenia (Lock & Lella, 1986). In keeping with Murphy's (1977) dictum that 'transcultural psychiatry should begin at home' the place psychiatrists should learn about similarities and differences ('real' or 'apparent', 'socially constructed' or otherwise) between people is in the context of their everyday work. The bulk of the South African transcultural psychiatry literature is engaged in the production of the image of another, separate world inhabited by blacks. When it is recognised that the clinical encounter between, say, a white psychiatrist and a Black person from a rural area, can be fruitfully understood not as a meeting point between two different worlds, but as a world of its own with complex cultural and socio-political underpinnings, that encounter begins to form the basis for change in theory and action. This can happen only if the simultaneous insertion of *both* the clinician *and* the patient into the ideologically constructed domain of the institutional clinical encounter is explored - and in such a way that is accessible to clinicians themselves.

It is an unfortunate though probably inevitable fact that, almost without exception, theorists who have attempted to explore the relationship between apartheid, mental health, and mental health services are academics not involved full-time in provision of clinical care either inside or outside of state structures. This has been a probable contributory factor to

three crucial features of the apartheid and mental health literature: *i*) the almost total silence regarding practical issues in the day-to-day management of institutional psychiatric life apart from the observation that services are unequal and facilities for blacks lacking; *ii*) the lack of attention to clinicians' experience of the 'otherness' of patients, however much clinicians may wish that they did not experience this 'otherness'; and *iii*) the lack of serious engagement with the reality that the bulk of mental health services in a future non-racial South Africa will be the inheritance from current state services. Future services will be neither completely new creations nor solely the product of small-scale 'alternative' facilities, currently the focus of much of the energy of progressive health workers (these include detainee services and community clinics).

My research forced me, a psychologist aligned with progressive movements in mental health circles, and, as is typical, a full-time academic, into close contact with institutionalised clinical psychiatry - contact I had not had since qualifying as a clinical psychologist in the early 1980s. It is currently a methodological commonplace to argue that the act of observation changes what is being observed, and my presence even as researcher seems to have had the potential to act as a node for future developments. This is so especially in view of the fact that many of the people with whom I spoke and whose work I observed felt dissatisfied with current psychiatric practice and were open to change. When I was due to present a paper on my work in psychiatric ward-rounds at a university seminar a few months after I had completed data collection, there was some feeling of disquiet in the Department of Psychiatry I had studied about what I might say and how it might be interpreted. In the event, the only members of the department apart from the head (who had been appointed after the time of my study) who came to the campus to attend the seminar were people I had observed in ward-rounds. On the strength of the seminar I was invited to give a talk on my findings to the staff of Psychiatric Casualty, and people's responses were enthusiastic. I have been asked to continue attending rounds at Eagle's

Nest when I return from sabbatical leave, as staff there feel that a perspective more informed by social theory will help them improve organisational structures and patient care. Interpreters, I am told, now introduce themselves and the ward-rounds to patients without being told to do so by clinicians conducting the interviews!

In reporting on these personal details I realise that I run the risk of being accused of losing academic distance and even of being self-congratulatory. There is an important point to be made, however. If this has been part of the response to what I have been doing as a researcher, then there must be some potential for change as a result of active engagement by progressive mental health workers with institutional psychiatry. An objection to my argument that immediately springs to mind is that to work in apartheid mental health structures, in however 'progressive' a manner, is to collaborate in the divisive and discriminatory state health system. This is unquestionably true, and there are direct parallels between the implications of such involvement and the function of some clinicians in simultaneously reproducing and subverting the *status quo*, as I have shown earlier in the dissertation.

There is however an important counter-argument. Recent South African history has shown that the segregated school, the factory floor, and the formerly segregated university, to name some instances, are all potential sites of mobilisation. Change cannot come about purely externally to existing structures - it must happen through them as well. From a more narrowly mental health perspective, furthermore, there is no political gain to be made by simply forgetting (and I use that term in the full political sense both with respect to South African politics - see Suttner & Cronin, 1986⁸ - and with respect to mental health care provision - see Cohen, 1988) the people who currently fill psychiatric institutions to overflowing. From the perspective of a longer political view, in addition, to mobilise in apartheid institutions around the cultural and political issues raised in this dissertation may

go some way to ensure the proper place of mental health issues in South Africa's future political agenda, especially if a national health service is to be established. This approach, furthermore, avoids the utopianism inherent in the expectation that radical political change will come soon to South Africa and that this change, should it occur, will create the space and provide the resources for rapid new developments in all sectors, including that of mental health care - hardly a priority in the rest of Africa, for example (Dawes, 1986; Maforah, 1987). Even if a revolution were around the corner, now would be the time to start transforming mental health services.

III. Summary and concluding comments

In this dissertation I have attempted to provide a context for understanding central themes in South African psychiatric theory and in an area of its clinical practice.

Part 1 was concerned with situating South African transcultural psychiatry both in terms of the literature available and in terms of the social position of the psychiatrist or allied mental health worker. The overview of the literature in Chapter 2 demonstrated the reified and, paradoxically, decontextualised manner in which culture tends to be written about in the field, and the interpenetration of subtle racism with concern for culturally appropriate models of conceptualising disorder and providing care. This literature was linked in Chapter 3 to the question of the relationship between apartheid and mental health. In this chapter the theme of position of the individual psychiatrist in relation to apartheid structures was introduced, a theme extended in Chapter 4. The chief concern of Chapter 4 was to explore the operation of international debates in psychiatry - notably, those concerning cultural relativism - when transposed to South Africa. Analysis of aspects of the transformation and local interpretation of key debates provided some background for the approach to the empirical research reported on in Parts 2 and 3. The issue of

Chapter 13: Conclusion

culture was shown to embrace not only the question of how people of different backgrounds present with and manage mental illness, but also to be relevant to an examination of clinicians' social position.

In Part 2, I presented and discussed findings emerging from my observations of practices in psychiatric ward-rounds in key units attached to a psychiatry department of a liberal South African university. Chapter 5 provided a theoretical and methodological background to this part of the dissertation, and argued that the study of ward-rounds in particular could assist in bridging the gap between microsocial and macrosocial analyses of institutional psychiatry. The discussion of ward-rounds in the psychiatric casualty unit of De Hoop General Hospital (Chapter 6) demonstrated that among the pressing cultural issues for psychiatry in this setting is the position of psychiatry as a medical specialty. The question of differences between people of different 'racial' backgrounds is very clearly not the only cultural issue in Psychiatric Casualty. Chapter 7 teased out some of the complexities of professional culture and the way that it constructs identities for patients in ward-rounds on the Black side of Eagle's Nest Psychiatric Hospital. The question of cultural difference was shown to be difficult and double-edged for all clinicians in this setting, Black and white, and the setting itself demonstrated some of the anomalies and contradictions in the provision of care within an institutionally racist context.

Through the use of loosely structured interviews with psychiatric registrars and a vignette exercise, Part 3 explored ways in which clinicians responsible for the bulk of patient care in the system under study talk about issues of cultural difference and race. Chapter 8 introduced the area and described the theory and methods used, with a particular focus on the relationship between qualitative and quantitative techniques. In Chapter 9, registrars' descriptions of how they viewed patients from different backgrounds were discussed, and some examples of internal inconsistency and ambivalence demonstrated. These issues

Chapter 13: Conclusion

were carried forward into the discussion, in Chapter 10, of registrars' talk about services available in the system. In spite of general support for the integration of facilities on the part of registrars, it appeared that registrars collaborated in the perpetuation of a racist system, part of the reason for which seemed to lie in the tension between responsibility to individual patients, and more general accountability to communities at large. The interface, once again, between professional issues in psychiatry and the specifics of the South African situation was explored. The vignette ranking exercise reported in Chapter 11 served to underscore many of the qualitative findings of the previous two chapters. The chapter also acted as a link to the discussion, in Chapter 12, of the contribution of the professional socialisation of registrars to ways in which they reproduce the system in which they work.

In the body of the current chapter, I have tried to provide a theoretical context for integrating the material presented in the rest of the dissertation. I have been particularly concerned to show that careful consideration of cultural issues in mental health practice is essential for the future of such practice in a post-apartheid South Africa. I hope that this dissertation has gone some way to illustrate and justify the view that progressive mental health theory and practice in South Africa must engage with the politics of the issue of culture in psychiatry, and with the politics of the everyday business of psychiatry itself.

With the current chapter I conclude the main thrust of the dissertation. I have decided however to add the rather more speculative postscript which follows in the next chapter so that I can situate the major work of the dissertation within broader concerns about mental health and mental health services in South Africa. The postscript cannot be seen as a conclusion for the dissertation itself as it briefly introduces issues not raised previously. It should be read as a note towards the development of a theory linking the emotions to the

Chapter 13: Conclusion

workings of the state and to the operation of political resistance in a country in civil turmoil.

Notes to Chapter 13

1. I am aware that I could have presented arguments for and against positions close to each of the poles of argument in a schematic and apparently more organised way than I choose to do here. This approach would have had the potential advantage of greater clarity, but it would also entail loss of a sense of the fabric of the tensions in the debates.
2. Littlewood's (in press) point was made with specific reference to studies in medical anthropology and sociology which tend to engage in 'minute dissections of doctor-patient interactions [seeing these] purely as reflections of medical power'. A more general point can however be induced - that medical or psychiatric practice cannot usefully be viewed purely as a site of the exercise of power. A sophisticated understanding of the issue of power is of course crucial to any work attempting to pay adequate attention to the complexities of clinical practice. Such an understanding requires as a starting point the recognition that power can be conceptualised in many ways, and not simply as the exercise of force (physical or metaphorical) on the part of one party against another (Simkins, 1986; Swartz et al, in press).
3. The charter was drawn up in the 1950s and is strongly associated with the Congress of the People campaign of 1955, and a period of mass action and organisation against the state (Suttner & Cronin, 1986). The charter forms a basis for the banned African National Congress (ANC), and United Democratic Front (UDF) policy, and is embraced by much of what has recently come to be known as the Mass Democratic Movement (MDM).
4. The registrar had definitely brought the calendar to display at work - we discussed this. It is possible that the copy of the Freedom Charter in the psychiatrist's office had been placed there by somebody else. The psychiatrist had not removed it.
5. This is a non-standard question, as orientation for person is usually assessed in the system by whether the patient can identify him/herself correctly and not by questions concerning identities of others.
6. See, for example, Kleinman's (1988a) transcription of an encounter between a psychiatrist in the United States and a patient who is a medical colleague (white, male, middle class and professional) in which the patient's illness experience is systematically ignored in favour of the construction of a disease picture. Kleinman (1986; 1988b) elsewhere demonstrates processes of objectification in Chinese psychiatry and in the management of chronic pain in the USA. Barrett (1988) and Harré (1985), from slightly different perspectives, show how the process of clinical note-taking transforms patients from persons into entities representing categories.
7. An important strength of Thornton's (1988) approach, like that of Sharp (1980), is that it insists that 'culture' can be used as a mode of mobilisation by people and groups with widely diverging interests. The image painted by Dommissie (1986), for example, of the happy, socially well-integrated Black in the pre-lapsarian days prior to conquest by white settlers, is ironically not radically different from dominant South African transcultural psychiatry's image of the true Black as a type of noble savage. Traditions, to paraphrase from the title of Hobsbawm and Ranger's (1984) collection, may be invented for a variety of purposes. Ranger's (1984) chapter on the invention of tradition in Africa has much that is relevant to an understanding of Dommissie's approach.
8. Suttner and Cronin (1986) use the term 'forgetting' to refer to the work of political repression, along the lines used by Kundera (1983) in *The book of laughter and forgetting*.

Chapter 14

The state, resistance, and the emotions in South Africa: notes towards a theory

Table of contents

I.	Introduction	343
II.	The development of alternative mental health services in South Africa	343
A.	Alternative services as messages to the state and the outside world	345
B.	Alternative services as messages to progressive people and organisations	346
III.	Implications and conclusions	347
	Notes	350

Chapter 14

The state, resistance, and the emotions in South Africa: notes towards a theory

I. Introduction

One of the necessary limitations of my research for this dissertation is that it has focussed almost exclusively on institutional psychiatric practice. I have paid scant attention to questions of patterns of distress in the community, and to processes of managing distress, not all of which, by any means, will involve referral to hospitals or even to any professional person. I have not, furthermore, entered into any detailed examination of the social construction of mental illness, labelling theory, and similar sociological concepts relevant to an understanding of the social networks of meaning leading to a person's taking on the role of 'mentally ill patient'. These issues are all relevant to any complete understanding of cultural factors in the construction of mental illness in South Africa.

The power of psychiatry as a discipline to mould patterns of emotional response both in psychiatric patients and more generally in all people living in psychiatrised societies has been well-documented (Castel et al, 1982; Herzlich & Pierret, 1984; Littlewood & Lipsedge, 1982; Miller & Rose, 1986). The data I have presented accords with this tradition of research. Given this psychiatric power and its particular realisation in South Africa, some difficult questions arise for clinicians wishing to contribute towards a fundamental change in power relations.

II. The development of alternative mental health services in South Africa

In South Africa at present, as elsewhere (Littlewood, 1988), there is considerable suspicion of professionals and their motives (Berger & Lazarus, 1987; Straker & the Sanctuaries Counselling Team, 1987; Lab, 1988; Skinner & Swartz, 1989; Swartz et al, in press; Swartz

& Levett, 1989). This is hardly surprising. Academic knowledge in South Africa has commonly been used in the deliberate or incidental reproduction of the current social order, as Part 1 of this dissertation has shown. Part of the challenge facing professionals - including mental health workers - is to transform their work in such a manner that they are able to contribute to emancipatory practice, and to empowerment as opposed to the use of knowledge as an oppressive tool. Webster (1986) has outlined some of the challenges and potential pitfalls along the path to what he terms a 'social science of liberation' in South Africa. Issues such as community participation (Hoffman et al, 1987, 1988; Katzenellenbogen et al, 1988), accountability (Manganyi & Du Toit, in press), the transfer of skills from professionals to others (S. Swartz et al, 1986; S. Swartz & L. Swartz, 1987), and the recognition of the existing strengths of non-professionals (De Villiers & Dawes, 1989; Narunsky, 1986) are all important and complex. I shall not consider these issues at any length here. I wish instead to consider a single topic: the role of progressive mental health workers in shaping responses to distress, and the relationship between this practice and the practice of dominant psychiatry.

The mushrooming of projects and facilities focussing on the mental health needs of oppressed South Africans, including people directly affected by state violence and detention, is a noteworthy feature of the recent history of the mental health professions in this country (Louw, in press; Swartz et al, in press)¹. Detainee services have sprung up, and modes of working with oppressed groups discussed and experimented with (Browde, 1988; Levenstein, 1988; Turton, 1986a). In keeping with principles of empowerment and transfer of professional skills, modes of training non-professionals in basic mental health care are widely explored (Nell & Seedat, 1989; Swartz & Swartz, 1986; Wood, 1989). These services, though at one level simply fulfilling a service need, have a much more complex set of ideological functions.

A. Alternative services as messages to the state and the outside world

The fact of services springing up to deal largely with what are viewed as victims of apartheid, unfortunate though victimological discourse may be in many respects (Foster & Skinner, in press; Swartz et al, in press; Swartz & Levett, 1989), provides an important political message about the state. If these services are indeed necessary, this implies that state violence and repression can be seen as psychopathogenic. This is a serious indictment, and lends professional credibility to arguments about state brutality. There is of course at one level an element of irony to the use of professional credibility in this way. Many left-wing clinicians, as we have seen, are engaged in attempts to deprofessionalise. The ambiguities of the use of professional status in this context are worthy of attention in themselves, but will not be dealt with here (Swartz, 1986b; Swartz et al, in press; Swartz & Levett, 1989).

Progressive mental health professionals share with health professionals in general (Rayner, 1987), and other groups such as lawyers (Davis & Slabbert, 1985; Foster et al, 1987) and teachers (Molteno, 1987), a political profile in exposing the negative and brutal aspects of apartheid, and foregrounding particular forms and strategies of resistance. The enormously high profile the church enjoys in the South African struggle, as in other political struggles (De Gruchy, 1986; Villa-Vicencio, 1987), stems partly from the accepted role of the church as arbiter of public morality. Credibility of professions in the struggle, similarly, relates partly to these professions' constructed association with high standards of ethics and morality (L. Swartz, 1988).

An interesting feature of the progressive political function of the professions in South Africa is that the actions of progressive professionals serve to throw into relief those of their non-progressive counterparts. Medical personnel who provide care for victims of torture and violence, for example, or for sectors of the population who are grossly underserved, foreground the behaviour of the practitioners who do not provide such care.

Lawyers concerned with human rights issues attack, even if at times implicitly and incidentally, the ethical position of other lawyers and of the judicial system in general (Murray et al, 1989). Mental health professionals, similarly, who train non-professionals in counselling skills, for example, simultaneously indicate that their colleagues not involved in such activities do not have the mental health of all South Africans at heart. Alternative services, then, go hand in hand with a redefining of the boundaries of acceptable professional practice, and with the appropriation by progressive practitioners of the extremely powerful language of professional ethics, morality and social responsibility. To maintain their position on the moral high ground, providers of alternative mental health services need to maintain a supply of clients, or 'victims' of state discrimination or repression. There is a direct analogy between this need and the 'need' argued to be a feature of dominant psychiatry to expand the boundaries of psychopathological discourse so that the profession may continue to exist (Miller & Rose, 1986)². A further aspect of this is considered below.

B. Alternative services as messages to progressive people and organisations

By taking seriously the mental health needs of oppressed South Africans, progressive psychiatrists and others are undoubtedly making an important and long overdue contribution to mental health care. Merely to speak of the 'existence' of mental health 'needs' however, is to play a part in creating such needs. Former detainees are counselled by detainee services, community workers are trained in detecting common and uncommon stress responses, people are encouraged to deal with their feelings of frustration, anger, and humiliation openly so that they are able to move forward in building a new South Africa (Swartz et al, in press). I believe all this to be necessary, but I cannot but note as well that part of the function of talk about dealing with psychological effects and realities is to pattern the production of such 'effects'. If anorexia nervosa and similar conditions, and stress reactions in particular, can be seen to be conditioned by dominant discourses (Littlewood & Lipsedge, 1986; Swartz, 1985a; Young, 1980), then by the same token a form

of patterning of emotional response may be seen to be operating in 'progressive' mental health discourse. Progressive clinicians, like clinicians of any cast, require that the people they treat be ill in a way that is amenable to the care they have to offer. This is a product simply of the necessary components for successful intervention and not a sign of callous manipulation. When we want to help apartheid's 'victims' we may, paradoxically, be providing part of the script of the victim role.

The ironies of this possibility go far deeper when one examines the theoretical underpinnings of the type of care progressive people offer. In counselling and self-help manuals, symptom clusters learned from training in dominant psychiatry and similar disciplines are presented as typical. Counselling sometimes accompanies a physical examination or takes place at a clinic, reinforcing the image of psychological distress as a medical condition. Psychotropic medication is sometimes prescribed. In many respects, the 'victim' of apartheid becomes a 'patient' - along the very lines that progressive clinicians might, in other contexts, label the medicalisation of political resistance.

Any experience of dealing with survivors of shootings, beatings, detentions and so on should be enough to convince anyone of the reality of feelings of distress amongst such people, and the relief with which many talk of their problems. It would be ludicrous for me to suggest that such distress does not exist, or that it is simply created by progressive practitioners. But it would be equally irresponsible not to concede that progressive practice must contribute to the way that illness behaviour of a very particular type is being constructed in South Africa.

III. Implications and conclusions

Much of this dissertation has been concerned with demonstrating ways in which clinicians in dominant South African psychiatry are engaged in cultural reproduction and in the construction of psychiatric disorder. Without viewing psychiatry itself as a cultural product,

I have suggested, it is not possible to develop an adequate cultural approach to psychiatry. I have rejected simple formulations about the South African psychiatrist as an evil racist, even though I have no doubt that racism operates every day even in the practice of 'liberal' South African psychiatry.

Part of the reason for my rejection of moralistic condemnation of South African psychiatry³ comes from my experience in progressive alternative mental health care. Engaging with the challenges of intervening with the consequences of apartheid may well be laudable. Even if we leave aside however the unquestionably correct assessment that working in such a way may also be an attempt to consolidate one's own power in a rapidly-shifting political environment (Seedat et al, 1989), the fact still remains that progressive practice must have its own power structures and does mimic aspects of dominant practice. This is inevitable, but, were the moralistic argument correct, it would be possible for progressive mental health workers simply to slough off the unfortunate aspects of dominant local psychiatry and create a new, morally pure practice. The fact that this has not happened, I suggest, has less to do with the moral inadequacy even of progressive practitioners, than with their own inevitable insertion into the social and political order.

In the prefatory chapter to this dissertation, I suggested that a primary feature of the 'new cross-cultural psychiatry' as properly understood is a self-reflective attitude towards one's own knowledge production and practice. If South African psychiatry is to be transformed to take greater and more adequate account of the mental health needs of all South Africans, this self-reflection is essential. A country so fundamentally and obviously affected by brutality and violence almost demands that the opposing psychopathological discourse of victims and psychiatric effects develop. This discourse is, in the end, not an alternative to dominant structures, but merely a counterpoint.

I am unable to give practical suggestions at this stage towards a more emancipatory practice in the mental health field in South Africa. I am decidedly not of the view that such

an endeavour must by definition reject all of the legacy of dominant psychiatry in order to establish its own identity. What does seem clear however is that progressive practice needs to examine itself as a cultural product and to recognise that many issues in the provision of psychiatric care have less to do with personal morality than with the role of institutions and the professions in the cultural order. If psychiatry and similar professions are to play a full role in South African liberation, part of that role must lie in the recognition that the professions themselves, regardless of how they are practised, embody core cultural values. Like the psychological experience of oppression, these values cannot be decided away - they are part of the material with which we shall have to work.

In working towards a political understanding of the emotions in South Africa, and a mode of practice which takes due account of this understanding, clinicians cannot afford to deny their own location within what they see as repressive structures. They must recognise their own role in producing images of emotions. The very language that is used to describe South African politics - words like 'repression', and 'resistance' are particularly salient examples - resonates with the psychologised language of the post-Freudian world. Refusal to give due attention to questions of cultural diversity, racial difference, and of everyday life in the psychiatric milieu, as discussed in the previous chapter, may represent an attempt by progressive practice to separate itself from dominant psychiatry. This has arguably been politically necessary until now. Part of the road ahead, however, may lie in an examination of progressive practice, just as I have examined dominant psychiatry in this dissertation. A first step along this path is to recognise that if dualistic analyses of South Africa into different 'worlds' - 'traditional' versus 'modern', 'black' versus 'white', and so on - are not very helpful, neither is the rigid distinction between the 'dominant order' in a field such as psychiatry and the 'new order'. A new psychiatry in South Africa will be no more unequivocally 'good' than the current psychiatry is uniformly and unequivocally 'bad'. The simple recognition of inevitable continuity between the two, ideological and otherwise, should go some way to encouraging progressive practice to engage more fully with issues affecting the everyday lives of most psychiatric patients in this country.

Chapter 14: Postscript

Notes to Chapter 14

1. At the same time, it should be noted that in terms of numbers of professionals engaged in such projects and their predominantly low status on professional hierarchies, the movement may be regarded as very much incidental to the mainstream.
2. I wish to reiterate here that I am part of the progressive movement of which I write, and I am not implying a Machiavellian 'labelling of people as crazy for the sake of the struggle' any more than I subscribe to the view that all human distress is the creation of psychiatrists. I do think it is important to note however that there are similarities between progressive and dominant practice.
3. I do not reject by any means the notion that South African psychiatrists are morally culpable for their actions, and I am convinced that many are far from blameless. I do not however believe that the language of morality and blame can provide an adequate explanation for South African psychiatric practice.

REFERENCES

References

- Abbott, A. (1988). *The system of the professions: an essay on the division of expert labor*. Chicago: Chicago University Press.
- African National Congress (ANC). (1986a, June). *The internal health situation in South Africa* (Paper No. 3/HCM/8/86). Paper presented at the 3rd ANC Health Council, Lusaka.
- African National Congress (ANC). (1986b, June). *Draft policy of the Health Department of the ANC (SA)*. (Paper No. 3/HCM/16/86). Paper presented at the 3rd ANC Health Council, Lusaka.
- African National Congress (ANC). (1986c, June). *Rehabilitation for victims of apartheid - a crippling disease: Planning for the future*. (Paper No. 3/HCM/19/86(B)). Paper presented at the 34th ANC Health Council, Lusaka.
- African National Congress (ANC). (1986d, June). *Some aspects for consideration in restructuring and developing health manpower resources*. (Paper No. 3/HCM/25/86). Paper presented at the 3rd ANC Health Council, Lusaka.
- Allen, I. (1988a). *Any room at the top? A study of doctors and their careers*. London: Policy Studies Institute.
- Allen, I. (1988b). *Doctors and their careers*. London: Policy Studies Institute.
- Allwood, C.W. (1979). *Psychiatry in primary health care in South Africa*. Unpublished master's dissertation, University of the Witwatersrand, Johannesburg.
- Allwood, C.W. (1985, April). *The psychiatric assessment of Black children - description of a cross-cultural experience*. Paper presented at the Fifth National Congress of the Association of Child Psychiatry, Psychiatry and Allied Disciplines, Bellville (Cape).
- Allwood, C. W. (1989). Personal communication.
- American Psychiatric Association (APA). (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). (DSMIII). Washington: American Psychiatric Association.
- American Psychiatric Association (APA). (1987). *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed., revised). (DSMIII-R). Washington: American Psychiatric Association.
- ANC. *see* African National Congress
- Andersson, N., & Marks, S. (1988). Apartheid and health in the 1980s. *Social Science and Medicine*, 27, 667-682.
- Anonymous. (1986). Some thoughts on a more relevant or indigenous counselling psychology in South Africa. *Psychology in Society*, 5, 81-89.
- Anspach, R. R. (1988). Notes on the sociology of medical discourse. *Journal of Health and Social Behavior*, 29, 357-375.
- Antaki, C. (Ed.). (1988a). *Analysing everyday explanation: a casebook of methods*. London: Sage.
- Antaki, C. (1988b). Explanations, communication and social cognition. In C. Antaki, (Ed.). *Analysing everyday explanation: a casebook of methods* (pp. 1-14). London: Sage.
- Antaki, C. (1989). Structured causal beliefs and their defence in accounts of student political action. *Journal of Language and Social Psychology*, 8, 39-48.

References

- APA. *see* American Psychiatric Association.
- Arluke, A. (1980). Roundsmanship: inherent control on a medical teaching ward. *Social Science and Medicine*, 14A, 297-302.
- Arney, R., & Bergen, B. (1984). *Medicine and the management of living: taming the last great beast*. Chicago: Chicago University Press.
- Atkinson, P. (1988a). Discourse, descriptions and diagnoses: reproducing normal medicine. In M. Lock & D. Gordon (Eds.). *Biomedicine examined* (pp. 179-204). Dordrecht: Kluwer.
- Atkinson, P. (1988b). Review of *The discourse of medicine* by Elliot G. Mishler (Norwood, NJ: Ablex, 1984). *Culture, Medicine and Psychiatry*, 12, 249-256.
- Bakkes, A. C. (1985). *Die doeltreffendheid van die NIPN Projektiewe Persoonlikheidstoets en die TAT-Z by die keuring van swart werknemers*. Unpublished master's dissertation, University of Pretoria, Pretoria.
- Barbee, J. A., Clark, P., Crapanzano, M. S., Heinitz, G. C., & Kehoe, C. E. (1989). Alcohol and substance abuse among schizophrenis patients presenting to an emergency psychiatric service. *Journal of Nervous and Mental Disease*, 177, 400-407.
- Barrett, R. J. (1988). Clinical writing and the documentary construction of schizophrenia. *Culture, Medicine and Psychiatry*, 12, 265-299.
- Bartocci, G., Pinto, M., Casini, S., Swart, W., & Badenhorst, T. (1975). *Psichiatria transculturale: un'indagine sulla sintomatologia acuta presentata da due gruppi razziali*. *Lavoro Neuropsichiatrico*, 56, 17-38.
- Ben-Arie, E. (1977, September). *A critical examination of the problems involved in studying Black personality in sub-Saharan Africa*. Paper presented at the 19th Annual Congress of the South African Psychological Association, Port Elizabeth.
- Ben-Arie, O., & Nash, E. (1986). Deficiencies and inequalities in psychiatric services (letter). *South African Medical Journal*, 69, 343-344.
- Ben-Arie, O., Swartz, L., & Dickman, B.J. (1987). Depression in the elderly living in the community: its presentation and features. *British Journal of Psychiatry*, 150, 169-174.
- Ben-Arie, O., Swartz, L., Teggins, A.F., & Elk, R. (1983). The Coloured elderly in Cape Town - a psychosocial, psychiatric and medical community survey. Part II. Prevalence of psychiatric disorders. *South African Medical Journal*, 64, 1056-1061.
- Benatar, S.R. (1989). Apartheid and medical care. *South African Medical Journal*, 75, 559.
- Berger, S., & Lazarus, S. (1987). The views of community organisers on the relevance of psychological practice in South Africa. *Psychology in Society*, 7, 6-23.
- Berglund, A.I. (1976). *Zulu thought-patterns and symbolism*. London: C.W. Hurst and Co. Ltd.
- Biesheuvel, S. (1987). Psychology: science and politics. Theoretical developments and applications in a plural society. *South African Journal of Psychology*, 17, 1-8.
- Black Health Workers and Patients Group (1983). Psychiatry and the corporate state. *Race and Class*, 25 (2), 49-64.
- Bloom, S. W. (1988). Structure and ideology in medical education: an analysis of resistance to change. *Journal of Health and Social Behavior*, 29, 294-306.

References

- Blumberg, L. (1983). Duodenal ulcer, urban stress and the concept of 'marginal man'. *South African Medical Journal*, 64, 630-632.
- Boonzaier, E. (1985). Choice of healer: An important area of interest for general practitioners. *South African Family Practice*, 6, 235-240.
- Boonzaier, E. (1988). 'Race' and the race paradigm. In E. Boonzaier & J. Sharp (Eds). *South African keywords: the use and abuse of political concepts* (pp. 58-67). Cape Town: David Philip.
- Boonzaier, E., & Sharp, J. (Eds). (1988). *South African keywords: the use and abuse of political concepts*. Cape Town: David Philip.
- Booyens, J.H. (1986). Etiologiese beskouinge van Twanasprekende stedelinge. *South African Journal of Ethnology*, 9, 3-25.
- Botha, B. C. (1985). The prevalence of hypertension in a specific industrial population. *South African Family Practice*, 6, 316-319.
- Botha, J. L., Bradshaw, D., Gonin, R., & Yach, D. (1988). The distribution of health needs and services in South Africa. *Social Science and Medicine*, 26, 845-853.
- Bourne, D. (1989). Nomenclature in a pigmentocracy: a scientist's dilemma. *South African Medical Journal*, 76, 185.
- BPS. see British Psychological Society.
- Brenner, M. H. (1973). *Mental illness and the economy*. Cambridge, Massachusetts: Harvard University Press.
- Bridgman, P. W. (1932). *The logic of modern physics*. New York: Macmillan.
- British Psychological Society (BPS). (1989). A resolution on apartheid. *The Psychologist*, August 1989, 328.
- Brittain, V., & Minty, A. S. (Eds.). (1988). *Children of resistance: on children, repression and the law in apartheid South Africa* (Statements from the Harare conference). London: Kluwer.
- Bromley, Y. V. (1987). Anthropology, ethnology, and ethnic and racial prejudice. *International Social Science Journal*, 111, 31-43.
- Browde, S. (1988). The treatment of detainees. In C. P. Owen (Ed.), *Towards a national health service: Proceedings of the 1987 National Medical and Dental Association Annual Conference* (pp. 105-110). Cape Town: NAMDA.
- Brown, L. J. (1980). Staff countertransference reactions in the hospital treatment of borderline patients. *Psychiatry*, 43, 333-345.
- Brown, M. F. (1988). Shamanism and its discontents. *Medical Anthropology Quarterly*, 2, 102-120.
- Brown, P. (1987). Diagnostic conflict and contradiction in psychiatry. *Journal of Health and Social Behavior*, 28, 37-50.
- Bührmann, M.V. (1977). Western psychiatry and the Xhosa patient. *South African Medical Journal*, 51, 464-466.
- Bührmann, M.V. (1978). Tentative views on dream therapy by Xhosa diviners. *Journal of Analytical Psychology*, 23, 105-121.

References

- Bührmann, M.V. (1980). Why are certain procedures of the indigenous healer effective? In F. Wilson & G. Westcott (Eds.). *Economics of health in South Africa*, Volume II (pp. 338-342). Johannesburg: Ravan.
- Bührmann, M.V. (1981). The Xhosa healers of Southern Africa. 1. Intlombe and xhentsa: A Xhosa healing ritual. *Journal of Analytical Psychology*, **26**, 187-201.
- Bührmann, M.V. (1982). Thwasa and bewitchment. *South African Medical Journal*, **61**, 877-879.
- Bührmann, M.V. (1983a). Archetypal transference as observed in the healing procedures of Xhosa amagqira. In J. Beebe (Ed.). *Money, food, drink and fashion and analytical training: Depth dimensions of physical existence*. (Papers of the 8th International Congress of Analytical Psychology) (pp. 249-258). Fellbach-Oeffingen (W.Germany): Bonz.
- Bührmann, M.V. (1983b). Training of Xhosa Medicine-men and analytical psychologists: A comparative study. In J. Beebe (Ed.). *Money, food, drink and fashion and analytical training: Depth dimensions of physical existence*. (Papers of the 8th International Congress of Analytical Psychology) (pp. 237-245). Fellbach-Oeffingen (W.Germany): Bonz.
- Bührmann, M.V. (1984a). *Living in two worlds: Communication between a white healer and her black counterparts*. Cape Town: Human & Rousseau.
- Bührmann, M.V. (1984b). The health care of an *igqira* (indigenous healer). In R.K. Papadopolous & G.S. Saayman (Eds.). *Jung in modern perspective*. London: Wildwood House and Cape Town: Ad. Donker.
- Bührmann, M.V. (1987). Initiation of Xhosa indigenous healers (*amagqira*). In L. C. Mahdi, S. Foster, & M. Little. (Eds.). *Betwixt and between: patterns of masculine and feminine initiation* (pp. 439-456). La Salle, Illinois: Open Court.
- Bührmann, M.V., & Gqomfa, J.N. (1981). The Xhosa healers of Southern Africa. 2. The songs sung in a healing ceremony. *Journal of Analytical Psychology*, **26**, 297-312.
- Bührmann, M.V., & Gqomfa, J.N. (1982a). The Xhosa healers of Southern Africa. 3. A family therapy session with a dream as central content. *Journal of Analytical Psychology*, **27**, 41-57.
- Bührmann, M.V., & Gqomfa, J.N. (1982b). The Xhosa healers of Southern Africa. 4. Isiko lentambo: A renewal sacrifice. *Journal of Analytical Psychology*, **27**, 163-173.
- Bulhan, A. H. (1981). Psychological research in Africa; genesis and function. *Race and Class*, **23** (1), 25-41.
- Bulhan, A. H. (1985). *Frantz Fanon and the psychology of oppression*. New York: Plenum Press.
- Burman, S., & Reynolds, P. (Eds.). (1986). *Growing up in a divided society: contexts of childhood in South Africa*. Johannesburg: Ravan.
- Bynum, W. F., Porter, R., & Shepherd, M. (Eds.). (1985). *The anatomy of madness* (2 vols). London: Tavistock.
- Campbell, G.D., Seedat, Y.K., & Daynes, G. (Eds.). (1982). *Clinical medicine and health in developing Africa*. Cape Town: David Philip.
- Carmil, D.B.S. (1980). *Fatalism, apathy and mental illness - the relationship between world view and mental illness among different cultural groups*. Unpublished doctoral dissertation, University of the Witwatersrand, Johannesburg.
- Carstens, C. (1985). *Die optimalisering van leer by swartes*. Unpublished master's dissertation, University of Pretoria, Pretoria.

References

- Cassell, J. (1987). On control, certitude, and the 'paranoia' of surgeons. *Culture, Medicine and Psychiatry*, 11, 229-249.
- Castel, R., Castel, F., & Lovell, A. (1982). *The psychiatric society*. New York: Columbia University Press.
- Castle, W.M., Hendrikz, E., & Jones, J.J. (1976). Measuring emotional stress in Africa: The difficulties involved and some results. *South African Medical Journal*, 50, 1143-1146.
- Caudill, W. (1958). *The mental hospital as a small society*. Cambridge, Massachusetts: Harvard University Press.
- Cheetham, R.W.S. (1975). Conflicts in a rural African patient treated in an urban setting. *Medicine 30 Psychiatric Disorders*, 3, 1563-1566.
- Cheetham, R.W.S., & Cheetham, R.J. (1976). Concepts of mental illness amongst the rural Xhosa people in South Africa. *Australian and New Zealand Journal of Psychiatry*, 10, 39-45.
- Cheetham, R.W.S., Edwards, S.D., Naidoo, L.R., Griffiths, J.A., & Singh, V.G. (1983). Deculturation as a precipitant of parasuicide in an Asian group. *South African Medical Journal*, 63, 942-945.
- Cheetham, R.W.S., & Griffiths, J.A. (1980). Changing patterns in psychiatry in Africa, with special relevance to South Africa. *South African Medical Journal*, 58, 166-168.
- Cheetham, R.W.S., & Griffiths, J.A. (1981). Errors in the diagnosis of schizophrenia in Black and Indian patients. *South African Medical Journal*, 59, 71-75.
- Cheetham, R.W.S., & Griffiths, J.A. (1982a). Sicknes and medicine - an African paradigm. *South African Medical Journal*, 62, 954-956.
- Cheetham, R.W.S., & Griffiths, J.A. (1982b). The traditional healer/diviner as psychotherapist. *South African Medical Journal*, 62, 957-958.
- Cheetham, R.W.S., & Rzadkowolski, A. (1980). Crosscultural psychiatry and the concept of mental illness. *South African Medical Journal*, 58, 320-325.
- Chodoff, P. (1982). Hysteria and women. *American Journal of Psychiatry*, 139, 545-551.
- Chrisman, N. J., & Maretzki, T. W. (Eds.). (1982). *Clinically applied anthropology: anthropologists in health science settings*. Dordrecht: Reidel.
- Christodoulou, N. (1983). *Hypertension in a number of South African blacks: A psychological study*. Unpublished doctoral dissertation, University of Pretoria, Pretoria
- Clare, A. (1976). *Psychiatry in dissent: controversial issues in thought and practice*. London Tavistock.
- Clark, I. (1982). Psychiatric emergency: Concepts and problems of organizational structure. *Sociology of Health and Illness*, 4, 75-85.
- Clifford, J., & Marcus, G. E. (Eds.). (1986). *Writing culture: the poetics and politics of ethnography*. Berkeley: University of California Press.
- Cock, J., & Nathan, L. (Eds.). (1989). *War and militarisation in South Africa*. Cape Town: David Philip.
- Cohen, D. (1988). *Forgotten millions*. London: Paladin.
- Coldwell, D.A.L. (1977). *Role conflict and job satisfaction amongst black industrial workers*. Unpublished master's dissertation, University of South Africa, Pretoria.

References

- Coldwell, D.A.L. (1985) Reply to Nzimande. *Psychology in Society*, 3, 43-48.
- Comaroff, J. (1981). Healing and cultural transformation: The Tswana of Southern Africa. *Social Science and Medicine*, 15B, 367-378.
- Comaroff, J. (1985). *Body of power, spirit of resistance. The culture and history of a South African People*. Chicago: Chicago University Press.
- Committee to visit South Africa (Stone, A., Pinder-Hughes, C., Spurlock, J., & Weinberg, J.). (1979). Report of the Committee to Visit South Africa. *American Journal of Psychiatry*, 136, 1498-1506.
- Corbett, K. K. (1986). *Adding insult to injury: cultural dimensions of frustration in the management of chronic back pain*. Unpublished doctoral dissertation, University of California at Berkeley with University of California at San Francisco.
- Coser, R. L. (1979). *Training in ambiguity: learning through doing in a mental hospital*. New York: The Free Press.
- Couve, C. (1984). *The psychologist and Black Consciousness in South Africa: The work of N.C. Manganyi*. Paper presented at Africa seminar, University of Cape Town, Cape Town.
- Couve, C. (1986). Psychology and politics in Manganyi's work: A materialist critique. *Psychology in Society*, 5, 90-130.
- Crane, J. (1976). Psychiatry at a mission hospital in South Africa. *Ulster Medical Journal*, 45, 73-75.
- Csordas, T. J. (1988). The conceptual status of hegemony and critique in medical anthropology. *Medical Anthropology Quarterly*, 2, 416-421.
- Dalal, F. (1988). The racism of Jung. *Race and Class*, 29 (3), 1-22.
- Daneel, M.H., Du Pisani, E., Jackson, B.T., Levin, A., Olivier, S.J., Strydom, L., & Uys, L.R. (The Interdisciplinary study group for Transcultural Research). (1984, March). *Some perceptions of disease among the urban blacks of Mangaung, Bloemfontein, South Africa - a preliminary report*. Paper presented at the Conference on African Healing Strategies, Florida (U.S.A.).
- Davis, D. M., & Slabbert, M. (Eds.). (1985). *Crime and power in South Africa: critical studies in criminology*. Cape Town: David Philip.
- Dawes, A. R. L. (1985). Politics and mental health: The position of clinical psychology in South Africa. *South African Journal of Psychology*, 15, 55-61.
- Dawes, A. R. L. (1986). The notion of relevant psychology with particular reference to Africanist pragmatic initiatives. *Psychology in Society*, 5, 28-48.
- Dawes, A. R. L. (in press). The effects of political violence on children: a consideration of South African and related studies. *International Journal of Psychology*.
- Dawes, A.R.L., & Davids, M.F. (1983). Is cross-cultural counselling possible? *Journal of the Educational Guidance Association*, 7, 5-8.
- Dawes, A. R. L., & De Villiers, C. (1989). Preparing children and their parents for prison: the Wynberg 7. In J. B. Mason & J. Rubenstein (Eds.). *Family therapy in South Africa today* (pp. 15-23). Congella, South Africa: South African Institute of Marital and Family Therapy

References

- Dawes, A. R. L., Tredoux, C., & Feinstein, A. (1989). Political violence in South Africa: some effects on children of the violent destruction of their community. *International Journal of Mental Health*, 18 (2), 16-43.
- Daynes, G. (1985). Is a combined Western and traditional health service for black patients desirable? (Letter). *South African Medical Journal*, 67, 400.
- Daynes, G., & Msengi, N.P. (1979). 'Why am I ill? Who made me ill?' The relevance of Western psychiatry in Transkei. *South African Medical Journal*, 56, 307-310.
- De Beer, C. (1984). *The South African disease: apartheid health and health services*. Johannesburg: South African Research Service.
- De Beer, C. (1986). Apartheid, health and health services in South Africa. *Proceedings of the Organization for Appropriate Social Services 'Apartheid and Mental Health' Conference* (pp. 13-20). Johannesburg: OASSSA.
- De Beer, F.E. (1980). *Meerdoelige opname onder swartes in stedelike gebiede, 1978. Besoeke aan toordokters*. Pretoria: Institute for Sociological and Demographic Research, Human Sciences Research Council. (Publication S-N-171).
- De Bruyn, A. C. S. (1985). *The role of Indian women*. Unpublished master's dissertation, University of Natal, Pietermaritzburg.
- De Gruchy, J. (1986). *The church and struggle in South Africa* (2nd ed.). Cape Town: David Philip.
- DeMilio, L. (1989). Psychiatric syndromes in adolescent substance abusers. *American Journal of Psychiatry*, 146, 1212-1214.
- De Ridder, J.C. (1961). *The personality of the urban African in South Africa: A thematic apperception test study*. London: Routledge & Kegan Paul.
- De Villiers, F. (1975, April 29). Millions out of madness. *Sunday Times*.
- De Villiers, S. (1984). *Popular medicine among Xhosa-speaking farm workers*. Unpublished master's dissertation, University of South Africa.
- De Villiers, S. (1985). (Consideration of) illness causation among some Xhosa-speaking people. *South African Journal of Ethnology*, 8, 45-52.
- Department of Psychiatry, University of Cape Town. (1986). Disaster, detention and mental health. (Letter). *South African Medical Journal*, 70, 370.
- Devereux, G. (1978). *Ethnopschoanalysis: psychoanalysis and anthropology as complementary frames of reference*. Berkeley and Los Angeles: University of California Press.
- Devereux, G. (1980). *Basic problems of ethnopsychiatry*. Chicago : University of Chicago Press.
- Dick, B., & Murray, P.J. (1978). Traditional healers and the medical profession. *South African Medical Journal*, 53, 311-312.
- Dick, B., Spencer, I.W.F., Watermeyer, G.S., Bourne, D.E., Wolff, E.P.M., & Moyle, G.D. (1978a). Chronic illness in non-institutionalized persons. Part I. Prevalence and epidemiology. *South African Medical Journal*, 53, 892-904.
- Dick, B., Spencer, I.W.F., Watermeyer, G.S., Bourne, D.E., Wolff, E.P.M., & Moyle, G.D. (1978b). Chronic illness in non-institutionalized persons. Part II. Who cares? *South African Medical Journal*, 53, 928-937.

References

- Dietz, P. E. (1981). Review of *Disposable patients: situational factors in emergency psychiatric decisions* by D. B. Matthews. *Psychiatry*, 44, 280-281.
- Dommisse, J. (1984a, June). Apartheid as a public mental health issue. Paper presented at the World Psychiatric Association Regional Symposium, Helsinki.
- Dommisse, J. (1984b, December). The psychological effects of apartheid (South African Naziism). Paper presented to the American Academy of Psychoanalysis 28th Winter Meeting, New York.
- Dommisse, J. (1986, June). *The state of psychiatry in South Africa today (1986)*: Paper presented at the Third African National Congress Health Council, Lusaka.
- Dommisse, J. (1987). The state of psychiatry in South Africa today. *Social Science and Medicine*, 24, 749-761 (includes comments by S. D Edwards and by S. P. Sashidharan and S. Platt, referenced separately, and a rejoinder by Dommisse).
- Dovey, K. (1983). Guidance and counselling services in the Republic of South Africa. *Personnel & Guidance Journal*, 61, 459-461.
- Dowdall, T.L. (1982). Behavior therapy in South Africa: A review. *Journal of Behavior Therapy and Experimental Psychiatry*, 13, 279-286.
- Draper, S. (1988). What's going on in everyday explanation? In C. Antaki, (Ed.). *Analysing everyday explanation: a casebook of methods* (pp.15-31). London: Sage.
- Du Preez, P. D. (1979). Politics and identity in South Africa. In P. Stringer & D. Bannister (Eds.). *Constructs of sociality and individuality* (pp. 341-364). London: Academic Press.
- Dubreuil, G. (1982). Abstracts of 'Categories of experience amongst the Xhosa: A psychological study' and 'Indigenous therapy in South Africa' by R.D. Schweitzer. *Transcultural Psychiatric Research Review*, 19, 46-52.
- Edwards, F.S. (1983a, June/July). Amafufunyana spirit possession: A report on some current developments. Paper presented at the Fifth Annual Congress for the Study of Religion. University of Durban-Westville.
- Edwards, F.S. (1983b). Healing and transculturation in Xhosa Zionist practice. *Culture, Medicine and Psychiatry*, 7, 177-198.
- Edwards, S. D. (1986). Traditional and modern medicine in South Africa: a research study. *Social Science and Medicine*, 22, 1273-1276.
- Edwards, S. D. (1987). Comment on 'The state of psychiatry in South Africa today' by John Dommisse. *Social Science and Medicine*, 24, 758.
- Edwards, S.D., Borsten, G.F., Nene, L.M., Grobbelaar, P.W., Makunga, N.V., Kunene, S.T., & Magwaza, A.S. (1983a). *Indigenous African healers and Western trained psychologists, a comparative study of interview methods*. Publications series of the University of Zululand, Series B, No. 386.
- Edwards, S.D., Cheetham, R.W.S., Majozi, E., Lasisch, A. (1982). Zulu culture-bound psychiatric syndromes. *South African Journal of Hospital Medicine*, 8, 82-86.
- Edwards, S.D., Cheetham, R.W.S., Majozi, E., & Makhwanazi, I. (1983d). The treatment of *umego* with hypnotherapy and cultural counselling: A case study. *Psychotherapeia*, 28, 34-29.
- Edwards, S.D., Grobbelaar, P.W., Makunga, N.V., Sibaya, P.T., Nene, L.M., Kunene, S.T., & Magwaza, A.S. (1983c). Traditional Zulu theories of illness in psychiatric patients. *Journal of Social Psychology*, 121, 213-221.

References

- Edwards, S.D., Grobbelaar, P.W., Nene, L.M., Makunga, N.V., Kunene, S.T., & Sibaya, P.T. (1983b). *Reaction to illness and concepts of mental illness among representative samples of rural, urban and university educated Black people*. Publications series of the University of Zululand, Series B, No. 26.
- Edwards, S.D., Jainarain, M., Randeree, F.A., Rzakowolski, A., & Wessels, W.H. (1982). Conversion disorders in Zulu patients. *South African Medical Journal*, 62, 97-99.
- Eisenberg, L. (1986). Is there too much science in medicine or not enough? A position paper. In S. McHugh, & T. M. Vallis (Eds.), *Illness behaviour: a multidisciplinary model* (pp. 33-45). New York: Plenum Press.
- Eisenberg, L. (1988). The social construction of mental illness. *Psychological Medicine*, 18, 1-19.
- Eisenberg, L., & Kleinman, A. (Eds.). (1981). *The relevance of social science for medicine*. Dodrecht: Reidel.
- Elk, R., Dickman, B.J., & Teggin, A.F. (1986). Depression in schizophrenia: A study of prevalence and treatment. *British Journal of Psychiatry*, 149, 228-229.
- Elk, R., & Nash, E.S. (1985). Hypertension in the aged: Psychological and psychiatric concomitants in a Coloured community. *South African medical Journal*, 67, 1046-1049.
- Elk, R., Swartz, L., & Gillis, L.S. (1983). The Coloured elderly in Cape Town - a psycho-social, psychiatric and medical community survey. Part I. Introduction and psychosocial data. *South African Medical Journal*, 64, 1017-1022.
- Els, N. J. S. (1984). *Hipertensie, sosiale heraanpassing en verstedeliking by swartes*. Unpublished master's dissertation, Rand Afrikaanse Universiteit, Johannesburg.
- Erasmus, J.A.K. (1978). The psychodynamics of duodenal ulceration in two rural black females. *Psychotherapeia*, 4(4), 26-28.
- Erasmus, P.F. (1975). *A survey of the literature on Bantu personality with particular reference to the TAT: An in-depth investigation*. Pretoria: Human Sciences Research Council Report: No. 10.
- Erikson, E. (1968). *Identity: youth and crisis*. London: Faber and Faber.
- Estroff, S. (1981). *Making it crazy: an ethnography of psychiatric clients in an American community*. Berkeley: University of California Press.
- Estroff, S. E. (1988). Whose hegemony? A critical commentary on critical medical anthropology. *Medical Anthropology Quarterly*, 2, 421-426.
- Fabrega, H., Jr. (1989a). An ethnomedical perspective of Anglo-American psychiatry. *American Journal of Psychiatry*, 146, 588-596.
- Fabrega, H., Jr. (1989b). Cultural relativism and psychiatric illness. *Journal of Nervous and Mental Disease*, 177, 415-425.
- Fanon, F. (1970). *Black skin, white masks*. London: Paladin.
- Farrand, D. (1980). *An analysis of indigenous healing in suburban Johannesburg*. Unpublished master's dissertation, University of the Witwatersrand, Johannesburg.
- Farrand, D. (1984). Is an integrated approach for black patients desirable? *South African Medical Journal*, 66, 779-780.
- Farrand, D. (n.d.) Psychiatric syndromes in black migrant workers. Unpublished paper.

References

- Farrand, D.M., & Holdstock, T.L. (1982). Dreams of a sangoma or indigenous healer. *Journal of African Studies*, 9, 68-75.
- Feinstein, A., Teeling-Smith, A., Moyle, D., & Savage, M. (1986). Some attitudes towards conscription in South Africa. *Psychology in Society*, 5, 66-80.
- Fernando, S. (1988). *Race and culture in psychiatry*. London: Routledge.
- Fielding, N. G., & Fielding, J. L. (1986). *Linking data: the articulation of qualitative and quantitative methods in social research*. Beverly Hills, California: Sage.
- Fisher, D.I. (1986). Amakhosi - a possible unexplored category of supernatural experience among the Xhosa. (Letter). *South African Medical Journal*, 70, 846-847.
- Fisher, S., & Groce, S. B. (1985). Doctor-patient negotiation of cultural assumptions. *Sociology of Health and Illness*, 7, 72-85.
- Fisher, S., & Todd, A. D. (Eds.). (1983). *The social organization of doctor-patient communication*. Washington: Center for Applied Linguistics.
- Fluxman, J. (1985). Psychiatry and apartheid. (Letter). *The Lancet*, 1 (8423) (Feb.), 283-4.
- Forrester, J. (1984). Who is in analysis with whom? Freud, Lacan, Derrida. *Economy and Society*, 13, 153-177.
- Foster, D., Davis, D., & Sandler, D. (1987). *Detention and torture in South Africa*. Cape Town: David Philip.
- Foster, D., & Skinner, D. (in press). Detention and violence: beyond victimology. In N. C. Manganyi & A. du Toit (Eds.). *Political violence in South Africa*. London: Macmillan.
- Foucault, M. (1973a). *Madness and civilization*. New York: Vintage.
- Foucault, M. (1973b). *The birth of the clinic: an archaeology of medical perception*. New York: Vintage.
- Foucault, M. (1974). *The archaeology of knowledge*. London: Tavistock.
- Foucault, M. (1979). *Discipline and punish: the birth of the prison*. New York: Vintage.
- Foucault, M. (1980). *The history of sexuality. Vol 1: an introduction*. New York: Vintage.
- Foucault, M. (1985). Sexuality and solitude. In M. Blonsky (Ed.). *On signs* (pp. 365-372). Baltimore: Johns Hopkins University Press.
- Frader, J. E., & Bosk, C. (1981). Parent talk at intensive care rounds. *Social Science and Medicine*, 15E, 267-274.
- Frankenberg, R. (1988). Gramsci, culture, and medical anthropology: Kundry and Parsifal? or rat's tail to sea-serpent? *Medical Anthropology Quarterly*, 2, 324-337.
- Freed, E. D., & Bishop, E. (1980). Major psychiatric disability in open ward patients referred by medical and surgical units at Baragwanath Hospital: A study of 1889 patients. *The Leech*, 50(3), 56-62.
- Freeman, M. C. (1984). *The effect of cultural variables on the Goodenough-Harris Drawing Test and the Standard Progressive Matrices*. Unpublished master's dissertation, University of the Witwatersrand, Johannesburg.

References

- Freeman, M. C. (1989a). *Mental health care in crisis in South Africa*. Paper No. 16, Centre for Health Policy, University of the Witwatersrand, Johannesburg.
- Freeman, M. C. (1989b, September). *The structure of mental health care services in South Africa*. Paper presented at the Conference of the Organisation for Appropriate Social Services in South Africa, University of the Witwatersrand, Johannesburg.
- Freud, S. (1950). *Totem and taboo. Some points of agreement between the mental lives of savages and neurotics*. London : Routledge and Kegan Paul.
- Furnham, A. F. (1988). *Lay theories: everyday understanding of problems in the social sciences*. Oxford: Pergamon.
- Gaines, A. D. (1979). Definitions and diagnoses: cultural implications of psychiatric help-seeking and psychiatrists' definitions of the situation in psychiatric emergencies. *Culture, Medicine and Psychiatry*, 3, 381-418.
- Gaines, A. D. (1982). Cultural differences, behavior and the person in American psychiatry. In A. J. Marsella & G. M. White (Eds.). *Cultural conceptions of mental health and therapy* (pp. 223-243). Dordrecht: Reidel.
- Gaines, A. D. (in press). Cultural constructivism and biomedicine: understanding ethnomedical knowledge and practice. *Medical Anthropology Quarterly*.
- Gallop, R., Lancee, W. J., & Garfinkel, P. (1989). How nursing staff respond to the label 'borderline personality disorder'. *Hospital and Community Psychiatry*, 40, 815-819.
- Garfinkel, H. (1967). *Studies in ethnomethodology*. Englewood Cliffs, New Jersey: Prentice-Hall.
- Geertz, C. (1984). Anti anti-relativism. *American Anthropologist*, 86, 263-278.
- Gellner, E. (1985) *Relativism and the social sciences*. Cambridge: Cambridge University Press.
- Gergen, K. J. (1982). *Towards social transformation in social knowledge*. New York: Springer.
- Gergen, K. J., & Davis, K. E. (Eds.). (1985). *The social construction of the person*. New York: Springer-Verlag.
- Gergen, K. J., & Gergen, M. M. (Eds.). (1984). *Historical social psychology*. Hillsdale, New Jersey: Lawrence Erlbaum Associates.
- Gergen, M. (1988). Narrative structures in social explanation. In C. Antaki, (Ed.), *Analysing everyday explanation: a casebook of methods*. London: Sage, pp. 94-112.
- Gibson, K. (1986). *The effects of civil unrest on children: A guide to research*. Unpublished master's dissertation, University of Cape Town, Cape Town.
- Gift, T. E., Strauss, J. S., & Young, Y. (1985). Hysterical psychosis: an empirical approach. *American journal of Psychiatry*, 142, 345-347.
- Gijana, E.W.M., & Louw, J. (1981). Psychiatric disorders in a developing community as reflected by archival material. *South African Medical Journal*, 59, 988-991.
- Gilbert, A. J. (1986). *Psychology and social change in the third world: a cognitive perspective*. Unpublished doctoral dissertation, University of South Africa, Pretoria.
- Gilbert, N., & Mulkay, M. (1984). *Opening Pandora's box: a sociological analysis of scientists' discourse*. Cambridge: Cambridge University Press.

References

- Gillis, L. S. (1975). Education for appropriate psychiatry. *South African Medical Journal*, 49, 112-116.
- Gillis, L. S. (1977). Mental health care in South Africa. *The Lancet*, 2, 920-921.
- Gillis, L. S. (1978). Mental health care in South Africa. *The Lancet*, 1, 767.
- Gillis, L. S. (1984). The diagnosis of psychiatric illness in different cultures (editorial). *South African Journal of Continuing Medical Education*, 2, 5-6 and 9.
- Gillis, L. S. (1985). Comment: Vera Bührmann, the pride of South African psychiatry. *Psychotherapeia and Psychiatry in Practice*, 36, 4.
- Gillis, L. S. (1986a). *Guidelines in psychiatry* (3rd edition). Cape Town: Juta.
- Gillis, L. S. (1986b). Readmissions to psychiatric hospitals. (Editorial). *South African Medical Journal*, 70, 715-716.
- Gillis, L. S. (1987). Psychiatric research - a new tomorrow. *South African Medical Journal*, 72, 797-799.
- Gillis, L. S., Elk, R., Ben-Arie, O., & Teggin, A.F. (1982). The Present State Examination: Experiences with Xhosa-speaking psychiatric patients. *British Journal of Psychiatry*, 141, 143-147.
- Gillis, L. S., Jakoet, A., Trollip, D., Sandler, R., & Elk, R. (1987a). The outcome of psychiatric illness: A 2-year follow-up study. *South African Medical Journal*, 72, 598-602.
- Gillis, L. S., Koch, A., & Joyi, M. (1989). Improving compliance in Xhosa psychiatric patients. *South African Medical Journal*, 72, 205-208.
- Gillis, L. S., Lewis, J. B., & Slabbert, M. (1965). *Psychiatric disturbance and alcoholism in the Coloured people of the Cape Peninsula*. Cape Town: University of Cape Town.
- Gillis, L. S., Sandler, R., Jakoet, A., & Elk, R. (1986a). Admissions to a psychiatric hospital: Factors associated with admission and inpatient care. *South African Medical Journal*, 70, 731-734.
- Gillis, L. S., Sandler, R., Jakoet, A., & Elk, R. (1986b). Readmissions to a psychiatric hospital: Outcome on follow-up. *South African Medical Journal*, 70, 735-739.
- Gillis, L. S., & Stone, G.L. (1973). A follow-up study of psychiatric disturbance in a Cape Coloured community. *British Journal of Psychiatry*, 123, 279-283.
- Gillis, L. S., & Stone, G.L. (1977). The fate of drinkers - a six year follow-up study of a community survey. *South African Medical Journal*, 51, 789-791.
- Gillis, L. S., Trollip, D., Jakoet, A., & Holden, T. (1987). Non-compliance with psychotropic medication. *South African Medical Journal*, 72, 602-606.
- Goffman, E. (1961). *Asylums*. New York: Doubleday.
- Goffman, E. (1975). *Frame analysis*. Harmondsworth: Penguin.
- Goldstein, J. (1982). The hysteria diagnosis and the politics of anticlericalism in late nineteenth-century France. *Journal of Modern History*, 54, 209-239.
- Good, B. J. (1977). The heart of what's the matter: the semantics of illness in Iran. *Culture, Medicine, and Psychiatry*, 1, 25-28.

References

- Good, B. J., & Good, M.-J. DelVecchio (1980) The meaning of symptoms: a cultural hermeneutic model for clinical practice. In L. Eisenberg & A. Kleinman (Eds.), *The relevance of social science for medicines* (pp. 165-196). Dordrecht: Reidel.
- Good, B. J., & Good, M.-J. DelVecchio (1981). The semantics of medical discourse. In E. Mendelsohn & Y. Elkana (Eds.). *Sciences and cultures: Sociology of the sciences Vol 5* (pp. 177-212). Dordrecht: Reidel.
- Good, B. J., & Good, M.-J. DelVecchio (1982). Toward a meaning centred analysis of popular illness categories. In A. Marsella & G. White (Eds.). *Cultural conceptions of mental health and therapy* (pp. 141-146). Dordrecht: Reidel.
- Good, B. J., Herrera, H., Good, M.-J. DelVecchio, & Cooper, J. (1985). Reflexivity, countertransference and clinical ethnography: a case from a psychiatric consultation clinic. In R. A. Hahn and A. D. Gaines (Eds.). *Physicians of western medicine* (pp. 193-221). Dordrecht: Reidel.
- Good, M.-J. DelVecchio, & Good, B. J. (1988). Ritual, the state, and the transformation of emotional discourse in Iranian society. *Culture, Medicine and Psychiatry*, 12, 43-63.
- Good, M.-J. DelVecchio, Good, B., & Fisher, M. M. J. (1988). Introduction: discourse and the study of emotion, illness and healing. *Culture, Medicine and Psychiatry*, 12, 1-7.
- Gordon, D. R. (1988). Tenacious assumptions in western medicine. In M. Lock & D. Gordon (Eds.). *Biomedicine examined* (pp. 19-56). Dordrecht: Kluwer.
- Grassroots. (1986). *Grassroots Community Newspaper*, 7(6), September.
- Groopman, L. C. (1987). Medical internship as moral education: an essay on the system of training physicians. *Culture, Medicine and Psychiatry*, 11, 207-227.
- Group Areas Act *see* Republic of South Africa.
- Hahn, R. A., & Gaines, A.D. (Eds.). (1985). *Physicians of western medicine: anthropological approaches to theory and practice*. Dordrecht: Reidel.
- Haldenwag, B.B. (1984). *Die Ruimtelike Verbreiding van Geestesiektes in Kaapstad*. Publication No. 12/1984, Institute for Cartographic Analysis, University of Stellenbosch.
- Halleck, S. L., & Woods, S. M. (1962). Emotional problems of psychiatric residents. *Psychiatry*, 25, 339-346.
- Hammond, M., & Buch, E. (1984, April). Community health workers in Mhala, Gazankulu: Perversion of a progressive concept? Paper No. 201 presented to the conference on the Second Carnegie Inquiry into Poverty and Development in Southern Africa. Cape Town.
- Hammond-Tooke, W. D. (1975). African world-view and its relevance for psychiatry. *Psychologia Africana*, 16, 25-32.
- Hammond-Tooke, W. D. (1981). *Boundaries and belief: The structure of a Sotho worldview*. Johannesburg: Witwatersrand University Press.
- Hammond-Tooke, W. D. (1989). *Rituals and medicines: traditional healing in South Africa*. Johannesburg: A D Donker.
- Hansen, V. (1987). Psychiatric service within primary care: mode of organization and influence on admission-rates to a mental hospital. *Acta Psychiatrica Scandinavica*, 76, 121-128.
- Harré, R. (1970). *Principles of scientific thinking*. Chicago: Chicago University Press.

References

- Harré, R. (1979). *Social being: a theory for social psychology*. Oxford: Basil Blackwell.
- Harré, R. (1985). Situational rhetoric and self-presentation. In J. Forgas (Ed.). *Language and social situations* (pp. 178-179). New York: Springer-Verlag.
- Harré, R. (Ed.). (1986). *The social construction of emotions*. Oxford: Basil Blackwell.
- Harré, R. (1988). Accountability within a social order: the role of pronouns. In C. Antaki, (ed.). *Analysing everyday explanation: a casebook of methods* (pp. 156-167). London: Sage.
- Harré, R., & Secord, P. F. (1972). *The explanation of social behaviour*. Oxford: Basil Blackwell.
- Hart, G.A.D. (1988). Medical education in South Africa with special reference to psychiatry. *The Leech*, 57(2), 45-47.
- Hayes, G. (1983). Madness and labour. *Work in progress*, 26, 20-26.
- Hayes, G. (1986). Intervening with the political psyche. *Proceedings of the Organization for Appropriate Social Services 'Apartheid and Mental Health' Conference* (pp. 44-48). Johannesburg: OASSSA.
- Hayes, G., & Nzimande, B. (1984). Introduction to Paulin Houtondji. *Psychology in Society*, 2, 4-10.
- Heap, M. (1985). *Health and disease in two villages in South-eastern Lesotho*. Unpublished master's dissertation, University of Cape Town, Cape Town.
- Heelas, P., & Lock, A. (Eds.). (1981). *Indigenous psychologies: anthropology of the self*. London: Academic Press.
- Helman, C. (1984). *Culture, health and illness*. Bristol: John Wright and Sons Ltd.
- Helman, C. (1987). Heart disease and the cultural construction of time: the Type A behaviour pattern as a western culture-bound syndrome. *Social Science and Medicine*, 25, 969-979.
- Helman, C. (1988). Psyche, soma, and society: the social construction of psychosomatic disorders. In M. Lock & D. Gordon (Eds.). *Biomedicine examined* (pp. 95-122). Dordrecht: Kluwer.
- Hemphill, R.E. (1987). Opinion: The Royal College of Psychiatrists and medical sanctions against South Africa. *South African Medical Journal*, 72, 659-660.
- Hemphill, R.E. (1988). The Royal College of Psychiatrists and medical sanctions against South Africa. (Letter). *South African Medical Journal*, 73, 63.
- Henning, P.H. (1982). Psychiatric illness. In G.D. Campbell, Y.K. Seedat & G. Daynes (Eds.), *Clinical medicine and health in developing Africa* (pp. 445-465). Cape Town: David Philip.
- Henriques, J., Hollway, W., Urwin, C., & Walkerdine, V. (1984). *Changing the subject. Psychology, social regulation and subjectivity*. London: Methuen.
- Herzlich, C., & Pierret, J. (1984). *Illness and self in society*. Baltimore: The Johns Hopkins University Press.
- Hirsch, S. J., & Hollender, M. H. (1969). Hysterical psychosis: clarification of the concept. *American Journal of Psychiatry*, 125, 909-915.
- Hobbs, S.B. (1981). *Toward an extended description of the lived-experience of the Indian factory worker*. Unpublished master's dissertation, University of Natal at Pietermaritzburg.

References

- Hobsbawm, E., & Ranger, T. (Eds.). (1984). *The invention of tradition*. Cambridge: Cambridge University Press.
- Hoffman, M., Yach, D., Katzenellenbogen, J., Pick, W., & Klopper, J. M. L. (1987). *Mamre Community Health Project: Working paper series no. 1: Rationale and methods (Baseline study)*. Cape Town: Mimeographed booklet, Department of Community Medicine, University of Cape Town, and the Centre for Epidemiological Research in South Africa.
- Hoffman, M., Yach, D., Katzenellenbogen, J. M., Pick, W., & Klopper, J. M. L. (1988). Mamre Community Health Project - rationale and methods. *South African Medical Journal*, 74, 323-327.
- Holden, T.J. (1987). Tardive dyskinesia in long-term hospitalised Zulu psychiatric patients: A prevalence study. *South African Medical Journal*, 71, 88-90.
- Holdstock, T.L. (1978, September). *Economic aspects of indigenous healing*. Paper presented at the conference on the Economics of Health Care in Southern Africa, University of Cape Town.
- Holdstock, T.L. (1979). Indigenous healing in South Africa: A neglected potential. *South African Journal of Psychology*, 9, 118-124.
- Holdstock, T.L. (1980). Indigenous healing in a parapsychological context. *Parapsychological Journal of South Africa*, 1, 1-13.
- Holdstock, T.L. (1981a). Indigenous healing in South Africa and the person-centered approach of Carl Rogers. *Curare*, 4, 31-46.
- Holdstock, T.L. (1981b). Psychology in South Africa belongs to the colonial era: Arrogance or ignorance? *South African Journal of Psychology*, 11, 123-129.
- Holdstock, T.L. (1981c). Recurring dreams of the people of sub-Saharan Africa. *Odyssey*, 5, 28-31.
- Holdstock, T.L., & Franks, P.E. (n.d.) *Urbanization and the belief in indigenous healers and Baloi (witchcraft)*. Unpublished paper.
- Holdstock, T.L., & Peltzer, K. (n.d.) *Cross-cultural divination in South Africa*. Unpublished paper. University of Witwatersrand.
- Hollender, M. H., & Hirsch, S. J. (1964). Hysterical psychosis. *American Journal of Psychiatry*, 120, 1066-1074.
- Houtondji, P. (1983). *African philosophy: myth and reality*. London: Hutchinson.
- Howell, D. C. (1987). *Statistical methods for psychology*. (2nd ed.). Boston: Duxbury Press.
- Hsu, K., & Marshall, V. (1987). Prevalence of depression and distress in a large sample of Canadian residents, interns, and fellows. *American Journal of Psychiatry*, 144, 1561-1566.
- Huberman, A. M., & Miles, M. B. (1985). Assessing local causality in qualitative research. In D. N. Berg and K. K. Smith (Eds.), *Exploring clinical methods for social research* (pp.351-381). Beverly Hills: Sage.
- Hughes, C. (1989). Commentary. On Fabrega and 'cultural relativism'. *Journal of Nervous and Mental Disease*, 177, 426-430.
- Hunt, L. M., Jordan, B., Irwin, S., & Browner, C. H. (1989). Compliance and the patient's perspective: controlling symptoms in everyday life. *Culture, Medicine and Psychiatry*, 13, 315-334.

References

- Hutton, P. H. (1988). Foucault, Freud, and the technologies of the self. In L. H. Martin, H. Gutman, & P. H. Hutton (Eds.), *Technologies of the self. A seminar with Michel Foucault* (pp.121-144). Boston: University of Massachusetts Press.
- Ingleby, D. (Ed.). (1981a). *Critical psychiatry*. Harmondsworth: Penguin.
- Ingleby, D. (1981b). Understanding 'mental illness'. In D. Ingleby, (Ed.). *Critical psychiatry* (pp. 23-71). Harmondsworth: Penguin.
- Ingleby, D. (1982). The social construction of mental illness. In P. W. G. Wright, & A. Treacher (Eds.). *The problem of medical knowledge: examining the social construction of medicine* (pp. 123-143). Edinburgh: University of Edinburgh Press.
- Ingleby, D., (1989). Critical psychology in relation to political repression and violence. *International Journal of Mental Health*, 17(4), 16-28.
- Jablensky, A. (1978). Mental health care in South Africa. *The Lancet*, 1, 270-271.
- Jackson, A. (Ed.). (1987). *Anthropology at home*. London: Tavistock.
- Jacobs, M., & Hollingshead, J. (1985). *Memorandum of children under repression*. Paper presented at the conference of the Health Workers' Society, Cape Town, October.
- Jansen, F.E. (1982). *An investigation into the scope of medical anthropology and the possibility of improving the effectiveness of cross-cultural medical services for South African blacks*. Unpublished master's dissertation, University of Port Elizabeth, Port Elizabeth.
- Jansen, F.E. (1983). The medical system as an aspect of culture and some acculturative effects of Western cross-cultural medical services. *South African Journal of Ethnology*, 6, 11-17.
- Jansen, G. (1973). *The doctor-patient relationship in an African tribal society*. Assen, The Netherlands: Van Gorcum & Comp. B. V.
- Janzen, J. (1978). *The quest for therapy in lower Zaire*. Berkeley: University of California Press.
- Jewkes, R. (1984). *The case for South Africa's expulsion from international psychiatry*. New York: UN Center Against Apartheid.
- Johnson, T. M. (1985). Consultation-liaison psychiatry: medicine as patient, marginality as practice. In R. A. Hahn & A. D. Gaines (Eds.), *Physicians of western medicine* (pp. 269-292). Dordrecht: Reidel. .
- Jones, M. O., Moore, M. D., & Snyder, R. C. (Eds.). *Inside organizations: understanding the human dimension*. Beverly Hills: Sage.
- Joubert, D. (1973). Raakpunte tussen psigatrie en sosiologie van belang vir die maatskaplike werker. *Maatskaplike Werk/Social Work*, 9(3), 160-164 & 188.
- Kaplan, H. I., & Sadock, B. J. (Eds.). (1988). *Comprehensive textbook of psychiatry/V* (2 vols). Baltimore: Williams & Wilkins.
- Karim, G.M. (1986). *The Islamisation of psychology*. Unpublished paper.
- Katz, S. E. (1982). Psychiatric hospitalization. In H. I. Kaplan, & B. J. Sadock (Eds.). *Comprehensive textbook of psychiatry/IV, Volume 2* (pp. 1576-1582). Baltimore: Williams & Wilkins.
- Katzenellenbogen, J. M., Pick, W. Hoffman, M., & Weir, G. (1988). Community participation in the Mamre Community Health Project. *South African Medical Journal*, 74, 335-338.

References

- Kaufman, S. R. (1988). Towards a phenomenology of boundaries in medicine: chronic illness experience in the case of stroke. *Medical Anthropology Quarterly*, 2, 338-354.
- Keen, P. (1978). Introducer: Panel discussion on the papers read at the Medical Students' Council's symposium on the role and place of the traditional medicine man and 'witchdoctor' in African health care. *The Leech*, 48(2), 19-24.
- Kelly, G. A. (1955). *The psychology of personal constructs*. New York: Norton
- Kingsbury, S. J. (1987). Cognitive differences between clinical psychologists and psychiatrists. *American Psychologist*, 42, 152-156.
- Kirk, J. K., & Miller, M. L. (1985). *Reliability and validity in qualitative research*. Beverly Hills: Sage.
- Kirmayer, L. J. (1988). Mind and body as metaphors: hidden values in biomedicine. In M. Lock & D. Gordon (Eds.). *Biomedicine examined* (pp. 57-93). Dordrecht: Kluwer.
- Kleinman, A. (1977). Depression, somatization and the new cross-cultural psychiatry. *Social Science and Medicine*, 11, 3-10.
- Kleinman, A. (1978). Clinical relevance of anthropological and cross-cultural research: concepts and strategies. *American Journal of Psychiatry*, 135, 427-431.
- Kleinman, A. (1980). *Patients and healers in the context of culture*. Berkeley: University of California Press.
- Kleinman, A. (1983). Editor's note. *Culture, Medicine, and Psychiatry*, 7, 97-99.
- Kleinman, A. (1986). *Social origins of distress and disease: depression, neurasthenia, and pain in modern China*. New Haven and London: Yale University Press.
- Kleinman, A. (1987) Anthropology and psychiatry: the role of culture in cross-cultural research on illness. *British Journal of Psychiatry*, 151, 447-454.
- Kleinman, A. (1988a). *Rethinking psychiatry: from cultural category to personal experience*. New York: Free Press.
- Kleinman, A. (1988b). *The illness narratives: suffering, healing and the human condition*. New York: Basic Books.
- Kleinman, A., Eisenberg, L., & Good, B. J. (1978). Culture, illness and care: clinical lessons from anthropological and cross-cultural research. *Annals of internal medicine*, 88, 251-258.
- Kleinman, A., & Good, B. J. (Eds.). (1985). *Culture and depression: studies in the anthropology and cross-cultural psychiatry of affect and disorder*. Berkeley: University of California Press.
- Kolb, L. C., & Brodie, H. K. H. (1982). *Modern clinical psychiatry*. Philadelphia: W. B. Saunders.
- Kottler, A. (1988). *South Africa: psychology's dilemma of multiple discourses*. Unpublished paper, Department of Psychology, University of Cape Town.
- Kovel J. (1981). *The age of desire. Reflections of a radical psychoanalyst*. New York : Pantheon Books.
- Kruger, D. (1974). Xhosa divining and psychotherapy - a reciprocal perspective. *Fort Hare Papers*, 6, 37-46.
- Kruger, D. (1978). Towards an understanding of the Xhosa diviner. *The Leech*, 48(2), 7-13).

References

- Kruger, D. (1980). The white therapist and the black client - a problem of cross-cultural contact. *Psychotherapeia*, 6(3), 25-32.
- Kruger, J. (1978). The medical profession and the witchdoctor. *South African Medical Journal*, 53, 431.
- Kuhn, T. (1970). *The structure of scientific revolutions*. Chicago: University of Chicago Press.
- Kuipers, J. C. (1989). 'Medical discourse' in anthropological context: views of language and power. *Medical Anthropology Quarterly*, 3, 99-123.
- Kundera, M. (1983). *The book of laughter and forgetting*. Harmondsworth: Penguin.
- Lab, S. G. (1988). *The psychological effects of unrest conditions on children with specific reference to South African townships*. Unpublished honours dissertation, University of the Witwatersrand, Johannesburg.
- Laing, R. D. (1960). *The divided self*. London: Tavistock.
- Laing, R. D., & Esterson, A. (1964). *Sanity, madness and the family: families of schizophrenics*. London: Tavistock.
- Lakoff, G. (1987). *Women, fire and dangerous things: what categories reveal about the mind*. Chicago: Chicago University Press.
- Lambley, P. (1973). Psychology and socio-political reality: Apartheid psychology and its links with trends in humanistic psychology and behaviour theory. *International Journal of Psychology*, 8, 73-79.
- Lambley, P. (1980). *The psychology of apartheid*. London: Secker & Warburg.
- Lambley, P., & Cooper, P. (1975). Psychotherapy and race: Interracial therapy under apartheid. *American Journal of Psychotherapy*, 29, 179-184.
- Lamla, C.M. (1976). *Present-day diviners (Ama-Gqira) in the Transkei*. Unpublished master's dissertation, University of Fort Hare, Alice.
- Lamont, A.McE. (1988). Severe invalidism - the dominant feature of Third-World psychiatry in Southern Africa. *South African Medical Journal*, 73, 430-33.
- Lang, C. L. (1982). The resolution of status and ideological conflicts in a community mental health setting. *Psychiatry*, 45, 159-171.
- Larsen, J.V., Msane, C.L., & Monkhe, M.C. (1983a). The Zulu traditional birth attendant - an evaluation of her attitudes and techniques and their implications for health education. *South African Medical Journal*, 63, 540-542.
- Larsen, J.V., Msane, C.L., & Monkhe, M.C. (1983b). The fate of women who deliver at home in rural KwaZulu - assessment of the place of traditional birth attendants in the South African health services. *South African Medical Journal*, 63, 543-545.
- Lasch, C. (1979). *The culture of narcissism: American life in an age of diminishing expectations*. New York: Warner.
- Laubscher, B.J.F. (1937). *Sex, custom and psychopathology*, London: Routledge and Kegan Paul.
- Laubscher, B.J.F. (1975). *The pagan soul*. Cape Town: Howard Timmins.
- Lawyers for Human Rights (1986). *The war against children: South Africa's youngest victims*. New York: Lawyers for Human Rights.

References

- Lazarus, E. S. (1988). Theoretical considerations for the study of the doctor-patient relationship: implications of a perinatal study. *Medical Anthropology Quarterly*, 2, 34-58.
- Lazarus, S. (1986). *Proposal/work in progress: The role and responsibility of the psychologist in the South African social context*. Unpublished paper, University of Cape Town, Cape Town.
- Lazarus, S. (1988). *The role and responsibility of the psychologist in the South African context*. Unpublished doctoral dissertation, University of Cape Town, Cape Town.
- Lee, R. (1981). Structure and anti-structure in the culture-bound syndromes: The Malay case. *Culture, Medicine and Psychiatry*, 5, 233-248.
- Lee, S.G. (1969). Spirit possession among the Zulu. In J. Beattie & R. Middleton (Eds.), *Spirit mediumship and society in Africa* (pp. 128-156). London: Routledge and Kegan Paul.
- Leff, J. (1981). *Psychiatry around the globe*. New York: Marcel Dekker, Inc.
- Leff, J. (1982). Review of *Aliens and alienists: ethnic minorities and psychiatry* by R. Littlewood and M. Lipsedge. *Psychological Medicine*, 12, 676-677.
- Leff, J. (1988). *Psychiatry around the globe*. (2nd ed.). London: Gaskell/ Royal College of Psychiatrists.
- Le Roux, A.G. (1973). Psychopathology in Bantu culture. *South African Medical Journal*, 47, 2077-2086.
- Le Roux, A.G. (1978). *Psychological factors in health*. University of the North publication series, B.15.
- Le Roux, A.G. (1979). Psychological factors in the health of South African blacks. *South African Medical Journal*, 56, 532-534.
- Le Roux, A.G. (1981). *Psigo-sosiale spanningsvelde in 'n veelrassige samelewing*. University of the North publication series C No. 17.
- Lethlaka, L.L.M. (1978). Experiences with witchdoctors and the feasibility of a referral system. *The Leech*, 48(2), 15.
- Levenstein, S. (1978). A report of three years' experience of a Balint group in Cape Town. *South African Medical Journal*, 54, 121-123.
- Levenstein, S. (1980). An undergraduate Balint group in Cape Town - a follow-up report. *South African Medical Journal*, 62, 89-90.
- Levenstein, S. (1988). Patient care in a repressive society (The doctor/patient relationship in an authoritarian society). In C. P. Owen (Ed.), *Towards a national health service: Proceedings of the 1987 National Medical and Dental Association Annual Conference* (pp. 100-104). Cape Town: NAMDA.
- Levenstein, S. (1989). Mental health in South Africa. In C. P. Owen (Ed.), *The case for a national health service* (pp. 63-76). Department of Adult Education and Extra-Mural Studies and the National Medical and Dental Association (Western Cape), University of Cape Town, South Africa.
- Levett, A. (1989). *Psychological trauma: discourses on child sexual abuse*. Unpublished doctoral dissertation, University of Cape Town, Cape Town.
- Levin, A., Schlebusch, L., Katzeff, I.E., Naidoo, N.K., Goolam-Hoosen, I., & Moshal, M.G. (1981). Psychosituational factors and duodenal ulceration in South African blacks and Indians. *South African Medical Journal*, 59, 5-8.

References

- Lewis, G., & Appleby, L. (1989). Personality disorder: the patients psychiatrists dislike. *British Journal of Psychiatry*, 153, 44-49.
- Lifschitz, S. (1989). The story of the cave or finding ways to create psychotherapeutic contexts with black clients. In J. B. Mason & J. Rubenstein (Eds.), *Family therapy in South Africa today* (pp. 46-50). Congella, South Africa: South African Institute of Marital and Family Therapy
- Lifton, R. J. (1986). *The Nazi doctors: medical killing and the psychology of genocide*. New York: Basic Books.
- Light, D. (1980). *Becoming psychiatrists: the professional transformation of the self*. New York: Norton.
- Lipton, M. (1985). *Capitalism and apartheid: South Africa 1910-1984*. London: Gower.
- Lishman, W. A. (1987). *Organic psychiatry: the psychological consequences of cerebral disorder*. Oxford: Blackwell Scientific Publications.
- Lison, S. (1976). *An MMPI based study of the personality characteristics of three groups of South African students*. Unpublished master's dissertation, University of Cape Town.
- Littlewood, R. (1985). Social anthropology in relation to psychiatry. *British Journal of Psychiatry*, 146, 552-554.
- Littlewood, R. (1988). Community initiated research: a study in psychiatrists' conceptualisations of 'cannabis psychosis'. *Bulletin of the Royal College of Psychiatrists*, 12, 486-488.
- Littlewood, R. (in press). From categories to contexts: a decade of the 'new cross-cultural psychiatry'. *British Journal of Psychiatry*.
- Littlewood, R., & Lipsedge, M. (1982). *Aliens and alienists: ethnic minorities and psychiatry*. Harmondsworth: Penguin.
- Littlewood, R., & Lipsedge, M. (1986). The 'culture-bound syndromes' of the dominant culture: culture, psychopathology and biomedicine. In J. L. Cox (Ed.), *Transcultural psychiatry* (pp. 253-273). London: Croom Helm.
- Littlewood, R., & Lipsedge, M. (1988). Psychiatric illness among British Afro-Caribbeans. *British Medical Journal*, 296, 950-951.
- Littlewood, R., & Lipsedge, M. (1989). *Aliens and alienists: ethnic minorities and psychiatry*. (2nd ed.). London: Unwin Hyman.
- Lock, M. (1987). DSM-III as a culture-bound construct: commentary on culture-bound syndromes and international disease classifications. *Culture, Medicine and Psychiatry*, 11, 35-42.
- Lock, M., & Gordon, D. (Eds.). (1988). *Biomedicine examined*. Dordrecht: Kluwer.
- Lock, M., & Lella, J. (1986). Reforming medical education: Towards broadening of attitudes. In S. McHugh, & T. M. Vallis, (Eds.). *Illness behaviour: a multidisciplinary model* (pp. 47-58). New York: Plenum Press.
- Loewenson, R. (1988). Labour insecurity and health: an epidemiological study in Zimbabwe. *Social Science and Medicine*, 27, 733-742.
- Lorber, J. (1972). Deviance as performance: the case of illness. In E. Friedson & J. Lorber (Eds.), *Medical men and their work* (pp. 414-424). Chicago: Aldine Atherton.
- Loring, M., & Powell, B. (1988). Gender, race, and DSM-III: a study of the objectivity of psychiatric diagnostic behavior. *Journal of Health and Social Behavior*, 29, 1-22.

References

- Louw, D. A. (Ed.). (1989). *Suid-Afrikaanse handboek van abnormale gedrag*. Johannesburg: Southern.
- Louw, J. (1986). *This is thy work: a contextual history of applied psychology and labour in South Africa*. Unpublished doctoral dissertation, University of Leiden.
- Louw, J. (in press). South Africa. In V. S. Sexton, & J. D. Hogan (Eds.). *Psychology around the world* (Second edition). Monterey: Brooks/Cole.
- Luiz, H.A. (1981). Profile of a psychiatric clinic in Soweto. *Transactions of the College of Medicine of South Africa*, 25, Supplementum, 187-190.
- Macdonnell, D. (1986). *Theories of discourse: an introduction*. Oxford: Basil Blackwell.
- Maforah, N. F. (1987). *The place of mental health institutions in developing countries, with special reference to Bophelong Psychiatric Hospital, Bophuthatswana*. Unpublished doctoral dissertation, University of South Africa, Pretoria.
- Mahabeer, M. (1980). *An investigation of the relationships between certain demographic and personality variables and death anxiety in Indian youth*. Unpublished master's dissertation. University of Durban-Westville, Durban.
- Mahabeer, M., & Bhana, K. (1984). The relationship between religion, religiosity and death anxiety among Indian adolescents. *South African Journal of Psychology*, 14, 7-9.
- Mahdi, L. C., Foster, S., & Little, M. (Eds.). (1987). *Between and between: patterns of masculine and feminine initiation*. La Salle, Illinois: Open Court.
- Makwe, E. R. (1985). *Western and indigenous psychiatric help-seeking in an urban African population*. Unpublished master's dissertation, University of the Witwatersrand, Johannesburg.
- Malcolm, J. (1989). The journalist and the murderer. *The New Yorker*, March 13, 1989, pp.38-73, and March 20, 1989, pp. 49-82.
- Manganyi, N. C. (1970). *Body image in paraplegia*. Unpublished doctoral dissertation, University of South Africa.
- Manganyi, N. C. (1973). *Being black in the world*. Johannesburg: Sprocas/Ravan.
- Manganyi, N. C. (1974). Health and disease. Some topical problems of sociocultural transition. *South African Medical Journal*, 48, 922-924.
- Manganyi, N.C. (1977). *Alienation and the body in racist society: A study of the society that invented Soweto*. New York: N.O.K.
- Manganyi, N. C. (1987). Ethics and the social responsibility of health workers. *South African Journal of Continuing Medical Education*, 5 (4) (April), 35-38.
- Manganyi, N. C., & du Toit, A. (in press). Introduction. In N. C. Manganyi & A du Toit (Eds.). *Political violence in South Africa*. London: MacMillan.
- Manning, P. K. (1987). *Semiotics and fieldwork*. Beverley Hills: Sage.
- Marcos, L.R., M. Alpert, L. Urcuyo and M. Kesselman (1973) The effect of interview language on evaluation of psychopathology in Spanish-American patients. *American Journal of Psychiatry*, 30, 549-553
- Marks, S., & Trapido, S. (Eds.). (1989). *The politics of race, class and nationalism in twentieth century South Africa*. Harlow: Longman.

References

- Marsella, A. J., & White, G.M. (Eds.). (1982). *Cultural conceptions of mental health and therapy*. Dodrecht: Reidel.
- Marshall, R. S. (1988). Interpretation in doctor-patient interviews: a sociolinguistic analysis. *Culture, Medicine and Psychiatry*, 12, 201-218.
- Martin, H. W. (1962). Structural sources of strain in a small psychiatric hospital. *Psychiatry*, 25, 347-353.
- Mason, J.B. (1984). Duodenal ulcer, urban stress and the concept of 'Marginal Man'. *South African Medical Journal*, 65, 193.
- Mason, J.B., Clark, P.M., Schelemmer, L., & Spitaels, J.M. (1986). Stressful life situations and perception of stress in black and Indian duodenal ulcer patients. *South African Medical Journal*, 70, 24-26.
- Mason, J.B., Moshal, M.G., Naidoo, V., & Schlemmer, L. (1981). The effect of stressful life situations on the healing of duodenal ulceration. *South African Medical Journal*, 60, 734-737.
- Mason, J. B., & Rubenstein, J. (Eds.). (1989) *Family therapy in South Africa today*. Congella, South Africa: South African Institute of Marital and Family Therapy
- McCabe, E.M.I. (1982). Lifestyle and disease: Alcoholism - its emergence in the black townships of South Africa. *South African Medical Journal*, 61, 881-882.
- McCann, R. J. T. (1983). *An interdisciplinary comparison concerning the nature of the treatment of psychiatric patients in South Africa*. Unpublished doctoral dissertation, University of Natal, Pietermaritzburg.
- McGovern D., & Cope, R. (1987a). First psychiatric admission rates of first and second generation Afro-Caribbeans. *Social Psychiatry*, 22, 139-149.
- McGovern D., & Cope, R. (1987b). The compulsory detention of males of different ethnic groups. *British Journal of Psychiatry*, 150, 505-512.
- McHugh, S., & Vallis, T. M. (Eds.). (1986). *Illness behaviour: a multidisciplinary model*. New York: Plenum Press.
- Mechanic, D., with Aiken, L. H., Greenley, J. R., Slesinger, D. P., Svarstad, B. L., & Tessler, R. (1976). *The growth of bureaucratic medicine: an inquiry into the dynamics of patient behavior and the organization of medical care*. New York: Wiley.
- Meer, F. (1976). *Race and suicide in South Africa*. London: Routledge and Kegan Paul.
- Mental Health Act see Republic of South Africa.
- Mercer, K. (1986). Racism and transcultural psychiatry. In P. Miller & N. Rose (Eds.), *The power of psychiatry*. (pp. 111-142). Cambridge: Polity Press.
- Merton, R. K., Reader, G. G., & Kendall, P. L. (Eds.). (1954). *The student physician*. Cambridge, Massachusetts: Harvard University Press.
- Mfenyana, K. (1988). Attitudes of rural African patients toward the use of drugs as prescribed by doctors. *South African Family Practice*, 9(4), 137-42.
- Mfusi, K.S. (1984). *The role of dreams for Zulu indigenous practitioners*. Unpublished master's dissertation, University of Zululand, Zululand.
- Milazi, D. (1986). Social and cultural basis of mental illness. *South African Journal of Ethnology*, 9, 175-180.

References

- Miles, M. B., & Huberman, A. M. (1984). *Qualitative data analysis: a sourcebook of new methods*. Beverly Hills: Sage.
- Milgram, S. (1974). *Obedience to authority: an experimental view*. London: Tavistock.
- Miller, P., & Rose, N. (Eds.). (1986). *The power of psychiatry*. Cambridge: Polity Press.
- Miller, T. D. (1988). *Clinical psychology in a general hospital setting: conflicts and paradoxes*. Unpublished master's dissertation, University of Cape Town, Cape Town, South Africa.
- Miller, T., & Swartz, L. (in press). Clinical psychology in general hospital settings: issues in interprofessional relationships. *Professional Psychology*.
- Millin, S. G. (1924). *God's step-children*. London: Constable.
- Mills, J. (1983). *Health, healing and dis-ease in a South African township*. Unpublished master's dissertation, University of Cape Town.
- Mills, J. (1985). The possession state *intwaso*: An anthropological re-appraisal. *South African Journal of Sociology*, 16, 9-13.
- Mills, J. (1987). Diviners as social healers within an urban township context. *South African Journal of Sociology*, 18, 7-13.
- Milne, F.J., James, S.H., & Veriava, J. (1989). Malignant hypertension and its renal complications in black South Africans. *South African Medical Journal*, 76, 164-167.
- Milner, G., & Hayes, G. (1988). Psychiatric illness among British Afro-Caribbeans (letter). *British Medical Journal*, 296, 1333.
- Minde, M. (1974a). History of mental health services in South Africa. Part I. In the days of the Dutch East India Company. *South African Medical Journal*, 48, 1270-1271.
- Minde, M. (1974b). History of mental health services in South Africa. Part II. During the British occupation. *South African Medical Journal*, 48, 1629-1632.
- Minde, M. (1974c). History of mental health services in South Africa. Part III. The Cape Province. *South African Medical Journal*, 48, 2230-2234.
- Minde, M. (1974d). History of mental health services in South Africa. Part IV. The Orange Free State. *South African Medical Journal*, 48, 2327-2330.
- Minde, M. (1975a). History of mental health services in South Africa. Part V. Natal. *South African Medical Journal*, 49, 322-326.
- Minde, M. (1975b). History of mental health services in South Africa. Part VI. The Transvaal. *South African Medical Journal*, 49, 367-374.
- Minde, M. (1975c). History of mental health services in South Africa. Part VII. Services since Union. *South African Medical Journal*, 49, 405-409.
- Minde, M. (1975d). History of mental health services in South Africa. Part VIII. Services for epileptics. *South African Medical Journal*, 49, 1568-1572.
- Minde, M. (1975e). History of mental health services in South Africa. Part IX. The protection and care of the feeble-minded. *South African Medical Journal*, 49, 1716-1720.

References

- Minde, M. (1975f). History of mental health services in South Africa. Part X. Institutions for defectives. *South African Medical Journal*, 49, 1890-1894.
- Minde, M. (1975g). History of mental health services in South Africa. Part XI. Services for alcoholics. *South African Medical Journal*, 49, 2197-2202.
- Minde, M. (1975h). History of mental health services in South Africa. Part XII. Services for criminals, delinquents and psychopaths. *South African Medical Journal*, 49, 2265-2270.
- Minde, M. (1976). History of mental health services in South Africa. Part XIII. The National Council for Mental Health. *South African Medical Journal*, 50, 1452-1456.
- Minde, M. (1977a). History of mental health services in South Africa. Part XIV. Psychiatric education. *South African Medical Journal*, 51, 210-214.
- Minde, M. (1977b). History of mental health services in South Africa. Part XV. The future of mental health services. *South African Medical Journal*, 51, 549-553.
- Minnaar, G.G. (1976). *The influence of Westernization on the personality of a group of Zulu men*. Pretoria: Human Sciences Research Council.
- Mishler, E. G. (1984). *The discourse of medicine: dialectics of medical interviews*. Norwood, NJ: Ablex.
- Mishler, E. G. (1986). *Research interviewing: context and narrative*. Cambridge, Massachusetts: Harvard University Press.
- Mixon, D. (1972). Instead of deception. *Journal for the Theory of Social Behaviour*, 2, 145-177.
- Mizrahi, T. (1984). Coping with patients: subcultural adjustments to the conditions of work among internists-in training. *Social Problems*, 32, 156-165.
- Mizrahi, T. (1987). Getting rid of patients: contradictions in the socialization of internists to the doctor-patient relationship. *Sociology of Health and Illness*, 7, 214-235.
- Mkhwanazi, I. M. (1986). *An investigation of the therapeutic methods of Zulu diviners*. Unpublished master's dissertation, University of South Africa, Pretoria.
- Mokhobo, K.P. (1978). The African medicine man and feasibility of referral. *The Leech*, 48(2), 14.
- Mokhuane, P. (1986). The management of psychiatric illness - The mental health worker and the community. *Maalskaplike werk praktyd/Social Work Practice*. (Nov), 4-5.
- Molteno, F. (1987). *1980 students struggle for their schools*. Cape Town: Centre for African Studies, University of Cape Town.
- Moore, S. F., & Myerhoff, B. G. (Eds.). (1977). *Secular ritual*. The Hague: Van Gorcum & Co.
- Morsy, S. A. (1988). Islamic clinics in Egypt: the cultural elaboration of biomedical hegemony. *Medical Anthropology Quarterly*, 2, 355-369.
- Moshal, M.G., Schlemmer, L., Mason, J., & Naidoo, N.K. (1979). A study of occupational status, responsibility and authority in patients with duodenal ulcers, other gastrointestinal diseases and controls. *Scandinavian Journal of Gastroenterology*, 14, Supplement 54, 31-40.
- Moyle, D. (1987). *Drawing the line: an early history of Valkenberg Hospital*. Unpublished honours project, Department of Psychology, University of Cape Town.

References

- Msengi, N.P., & Daynes, G. (1981). Community response to mental illness in Transkei. *South African Medical Journal*, 59, 47-49.
- Murphy, H. B. M. (1982). *Comparative psychiatry: the international and intercultural distribution of mental illness*. New York: Springer-Verlag.
- Murphy, H. B. M. (1977). Transcultural psychiatry should begin at home. *Psychological Medicine*, 7, 369-371.
- Murphy, J. M. (1976). Psychiatric labelling in cross-cultural perspective. *Science*, 191, 1019-1028.
- Murray, Christina., Sloth-Nielsen, J., & Tredoux, C. (1989). The death penalty in the Cape Provincial Division: 1986-1988. *South African Journal on Human Rights*, 5, 155-182.
- Murray, Colin. (1981). *Families divided: the impact of migrant labour in Lesotho*. Johannesburg: Ravan.
- Murray, T. H. (1986). Divided loyalties for physicians: social context and moral problems. *Social Science and Medicine*, 23, 827-832.
- Myers, J.E. (1984). *Psycho-social stress and the health of South African industrial workers*. Unpublished paper, Industrial Health Research Group, University of Cape Town.
- Myers, J.E., White, N., & Cornell, J.E. (1982). Prevalence of hypertension in semi-skilled manual workers. *South African Medical Journal*, 62, 894-898.
- Narunsky, C. (1986). Addressing child development issues in a community context: the Western Township Project. *Proceedings of the Organization for Appropriate Social Services 'Apartheid and Mental Health' Conference* (pp. 74-76). Johannesburg: OASSSA.
- Nash, E.S., & Meiring, P.de V. (1983). The Coloured elderly in Cape Town - a psychosocial, psychiatric and medical community survey. Part III. A survey of physical disorders and disabilities. *South African Medical Journal*, 64, 1089-1094.
- Nash, E.S., Stoch, M.B., & Harper, G.D. (1984). *Human Behaviour*. Cape Town: David Philip.
- Navarro, V. (1976). *Medicine under capitalism*. New York: Prodist.
- Navarro, V. (1986). *Crisis, health, and medicine: a social critique*. New York: Tavistock.
- Naylor, C. D. (1988). Private medicine and the privatisation of health care in South Africa. *Social Science and Medicine*, 27, 1153-1170.
- Nell, V., & Seedat, M. (1989). 'Western style family therapy in the Soweto primary health care system. In J. B. Mason & J. Rubenstein (Eds.). *Family therapy in South Africa today* (pp. 40-45). Congella, South Africa: South African Institute of Marital and Family Therapy
- Neumann, E. (1954). *The origins and history of consciousness*. Boston: Princeton University Press.
- Ngcobo, N.D.W. (1981). *Psychotherapy: Its relevance to Blacks: A theoretical investigation*. Unpublished master's dissertation, University of Natal, Pietermaritzburg.
- Ngubane, H. (1975). The place of spirit possession in Zulu cosmology. In M.G. Whisson & M.E. West (Eds.). *Religion and social change in Southern Africa* (pp. 48-57). Cape Town: David Philip.
- Ngubane, H. (1976). Aspects of Zulu treatment. In J.B. Loudon (Ed.). *Social anthropology and medicine* (pp. 318-357). London: Academic Press.
- Ngubane, H. (1977). *Body and mind in Zulu medicine: An ethnography of health and disease in Nyuswa-Zulu thought and practice*. London: Academic Press.

References

- Ngubane, H. (1981). Aspects of clinical practice and traditional organization of traditional healers in South Africa. *Social Science and Medicine*, 15B, 361-365.
- Ngubane, H. (1988) *Reshaping social anthropology*. Paper presented at the University of Durban-Westville, August.
- Nightingale, E. O., & Stover, E. (1985). Toward the prevention of torture and psychiatric abuse. In E. Stover & E. O. Nightingale (Eds.). (for the American Association for the Advancement of Science) *The breaking of bodies and minds: torture, psychiatric abuse, and the health professions*. New York: W. H. Freeman.
- Nissim-Sabat, C. (1987). On Clifford Geertz and his 'anti anti-relativism'. *American Anthropologist*, 89, 935-939.
- Nzimande, E.B. (1983). *The experience of being a black factory worker in South Africa*. Unpublished master's dissertation, University of Natal at Pietermaritzburg.
- Nzimande, E.B. (1984). Industrial psychology and the study of black workers in South Africa: A review and critique. *Psychology in Society*, 2, 54-91.
- Oberholzer, D.J. (1985). Co-operative venture with traditional healers in providing a community mental health service in the Odi I district, Bophuthatswana: A preliminary review. *Psychotherapeia and Psychiatry in Practice*, 36, 36-42.
- Oberholzer, D. (1986). Depression in the eighties: Black Population. *Psychotherapeia*, 43, 9-11.
- O'Connell, M.C. (1980). The aetiology of thwasa. *Psychotherapeia*, 6(4), 18-23.
- O'Connell, M.C. (1982). Spirit possession and role stress among the Xesibe of Eastern Transkei. *Ethnology*, 21, 21-37.
- Odejide, A. O., Oyewunmi, L. K., & Ohaeri, J. U. (1989). Psychiatry in Africa: an overview. *American Journal of Psychiatry*, 146, 708-716.
- Olinick, S. (1980). The gossiping analyst. *International Review of Psycho-Analysis*, 7, 439-445.
- O' Meara, K. (1983). *Volkskapitalisme*. Johannesburg: Ravan.
- Opie, L.H. (1989). The total costs and demands of treatment of hypertension in South Africa (Opinion). *South African Medical Journal*, 76, 85-88.
- Owen, C. P. (Ed.). (1988). *Towards a national health service*. (Proceedings of a National Medical and Dental Association conference held at the University of the Western Cape, Bellville, April 1987). Cape Town : NAMDA.
- Owen, C. P. (Ed.). (1989). *The case for a national health service*. Department of Adult Education and Extra-Mural Studies and the National Medical and Dental Association (Western Cape), University of Cape Town, South Africa.
- Patterson, S. (1989). Decoding the keywords of ethnicity: South African - and British. *Anthropology Today*, 5(3), 19-23.
- Pedersen, P., Sartorius, N., & Marsella, A. J. (Eds.). (1984). *Mental health services: the cross-cultural context*. Beverley Hills: Sage.
- Peshkin, A. (1985). Virtuous subjectivity: in the participant-observer's I's. In D. N. Berg & K. K. Smith (Eds.). *Exploring clinical methods for social research* (pp. 267-281). Beverly Hills: Sage.

References

- Pillay, H.M. (1984). The concepts, 'causation', 'racism' and 'mental illness'. *International Journal of Social Psychiatry*, 30 (1-2): 29-39.
- Population Registration Act *see* Republic of South Africa.
- Porter, R. (1985). *Patients and practitioners: lay perceptions of medicine in pre-industrial society*. Cambridge: Cambridge University Press.
- Porter, R. (1987). *A social history of madness*. London: Weidenfeld and Nicholson.
- Posel, D. (1983). Rethinking the 'race-class' debate in South african historiography. *Social Dynamics*, 9, 50-66.
- Posel, D. (1984). Language, legitimation and control: The South African state after 1978. *Social Dynamics*, 10, 1-16.
- Potgieter, W. (1986). *Die werksku kleurlingman: 'n Psigodiagnostiese ondersoek*. Unpublished master's dissertation, Potchefstroomse Universiteit vir Christelike Hoër Onderwys, Potchefstroom.
- Potter, J., & Collie, F. (1989). 'Community care' as persuasive rhetoric: a study of discourse. *Disability, Handicap and Society*, 4, 57-64.
- Powis, P.J. (1984). *Psychopathology in urban children*. Unpublished master's dissertation, University of South Africa, Pretoria.
- Price, M. (1988). The consequences of health service privatisation for equality and equity in health care in South Africa. *Social Science and Medicine*, 27, 703-716.
- Price, M., & de Beer, C. (1989). Can privatisation solve the problems in the health sector? In C. P. Owen (Ed.), *The case for a national health service* (pp.29-50). Department of Adult Education and Extra-Mural Studies and the National Medical and Dental Association (Western Cape), University of Cape Town, South Africa.
- Price, M., Steinberg, M., & De Beer, C. (NAMDA Constitution Group). (1986). The new constitution and health. In A.B. Zwi & L.D. Saunders (Eds), *Towards health care for all (NAMDA Conference '85)*. Johannesburg: NAMDA.
- Prince, E. F., Frader, J., & Bosk, C. (1982). On hedging in physician-physician discourse. In R. J. Di Pietro (Ed.). *Linguistics and the professions*. (Proceedings of the second annual Delaware Symposium on Language Studies) (pp. 83-97). Norwood, New Jersey: Ablex.
- Prince, R. (1983). Review of *psychiatry around the globe: a transcultural view* by Julian Leff. *Transcultural Psychiatric Research Review*, 20, 114-118.
- Prince, R. (1985). The concept of culture-bound syndromes: anorexia nervosa and brain-fag. *Social Science and Medicine*, 21, 197-203.
- Prince, R., & Tchong-Laroche, F. (1987). Culture-bound syndromes and international disease classifications. *Culture, Medicine and Psychiatry*, 11, 3-20.
- Psychology in Society (1983). Editorial. *Psychology in Society*, 1, 1-20.
- Psychotherapeia. (1977). The medicine-man or traditional healer (Editorial). *Psychotherapeia*, 3(3), 1-2.
- Psychotherapeia. (1980). 'n Afrika psigatrie? (Editorial). *Psychotherapeia*, 6(3), 1.
- Raath, A.H. (1984). *Psigoterapeutiese intervensie in die assimilasie van interpersoonlike vaardighede by swart universiteitstudiante*. Unpublished doctoral dissertation, University of the North.

References

- Rabinow, P., & Sullivan, W. M. (Eds.). (1979). *Interpretive social science: a reader*. Berkeley: University of California Press
- Rack, P. (1982). *Race, culture, and mental disorder*. London: Tavistock.
- Ramasuvha, V.S. (1982). Aspects of stress among traditionally living people in a developing country. *South African Medical Journal*, 61, 879-880.
- Ranger, T. (1984). The invention of tradition in colonial Africa. In E. Hobsbawm, & T. Ranger, (Eds.), *The invention of tradition* (pp. 211-262.). Cambridge: Cambridge University Press.
- Raubenheimer, P. M. (1986). *The nature of depression among blacks*. Unpublished master's dissertation, University of the Orange Free State, Bloemfontein.
- Rayner, M. (1987). *Turning a blind eye? Medical accountability and the prevention of torture in South Africa*. Washington, DC: American Association for the Advancement of Science.
- Repression Monitoring Group (RMG). (1986a). *The week that was*, No. 8, 28 April - 3 May. Mimeo.
- Repression Monitoring Group (RMG). (1986b). *The week that was*, No. 19. 14-20 July. Mimeo.
- Repression Monitoring Group (RMG). (1986c). *The week that was*, No. 27. 8-14 September. Mimeo.
- Repression Monitoring Group (RMG). (1986d). *The week that was*, No. 30. 29 September - 5 October. Mimeo.
- Repression Monitoring Group (RMG). (1986e). *The week that was*, No. 33. 20-26 October. Mimeo.
- Republic of South Africa. (1950a). *Group Areas Act, number 41 of 1950* (amended various times). Pretoria: Government Printer.
- Republic of South Africa. (1950b). *Population Registration Act, number 30 of 1950* (amended various times). Pretoria: Government Printer.
- Republic of South Africa. (1953). *Separate Amenities Act, number 49 of 1953* (amended various times). Pretoria: Government Printer.
- Republic of South Africa. (1973). *Mental Health Act, number 18 of 1973* (amended various times). Pretoria: Government Printer.
- Richman, S. (1986). *Stress and stress coping mechanisms employed by pre-school teachers in the Black townships of Cape Town in relation to the South African crisis*. Unpublished honours project, Department of Psychology, University of Cape Town, Cape Town.
- Ricoeur, P. (1977). The question of proof in Freud's psychoanalytic writings. *Journal of the American Psychoanalytic Society*, 25, 835-871.
- Robbertze, J.H. (1976). Psigoterapie. Waarheen is ons op weg? Paper presented at the 2nd Biennial Congress of the South African Psychiatric Association, Pretoria.
- Robbertze, J.H. (1978). The traditional 'healers'. (Editorial). *Psychotherapeia*, 4(4), 1.
- Robbertze, J.H. (1980). Mental health priorities in South Africa. In F. Wilson & G. Westcott (Eds), *Economics of health in South Africa, Vol. II* (pp. 312-328). Johannesburg: Ravan.
- Rogers, C. (1961). *On becoming a person*. Boston: Houghton Mifflin.

References

- Rogow, A. A. (1971). *The psychiatrists*. London: George Allen & Unwin.
- Rosenfield, S. (1984). Race differences in involuntary hospitalization: Psychiatric vs. labeling perspectives. *Journal of Health and Social Behavior*, 25, 14-23.
- Rottanburg, D. (1982). *A toxicological study of acute psychoses in Cape Coloured males with special reference to the cannabinoids*. Unpublished master's dissertation, University of Cape Town, Cape Town.
- Rottanburg, D., Robins, A.H., Ben-Arie, O., Teggin, A.F., & Elk, R. (1982). Cannabis-associated psychosis with hypomanic features. *Lancet*, 2, 1364-1366.
- Roux, G.H. (1977). Traditional healers and the medical profession. *South African Medical Journal*, 52, 627-630.
- Russel, A.S. (1985). Psychiatry and apartheid. (Letter). *The Lancet*, 1 (8423), (Feb.), 283.
- Rychlak, J. (1982). Some psychotherapeutic implications of logical phenomenology. *Psychotherapy : Theory, Research and Practice*, 19, 259-265.
- Saayman, G. S. (Ed.). (in press). *Modern South Africa in search of a soul: Jungian perspectives on the wilderness within*. Boston: Sigo Press.
- Sachs, D. M., & Shapiro, S. H. (1976). On parallel processes in therapy and teaching. *Psychoanalytic Quarterly*, 45, 394-415.
- Said, E. W. (1978). *Orientalism*. London: Routledge and Kegan Paul.
- Said, E. W. (1985). Orientalism reconsidered. *Race and Class*, 27 (2), 1-15.
- SAIRR. see South African Institute of Race Relations.
- Sashidharan, S. P. (1981). South Africa and the Royal College of Psychiatrists. *The Lancet*, 2, 1049.
- Sashidharan, S. P., Cox, J.L., Orley, J., Shoenberg, E., Webster, J., Rack, P., Littlewood, R., Lipsedge, M.S., & Davis, B. (1982). South Africa and the Royal College of Psychiatrists. *The Lancet*, 2, 497-498.
- Sashidharan, S. P., & Lipsedge, M. (1986). Schizophrenia and ethnicity (letter). *British Journal of Psychiatry*, 148, 484.
- Sashidharan, S. P., & Platt, S. (1987). Comment on 'The state of psychiatry in South Africa today' by John Domisse. *Social Science and Medicine*, 24, 758-760.
- Saucier, J.G. (1984). Abstract of 'Spirit possession and role stress among the Xesibe of Eastern Transkei' by M.C. O'Connell. *Transcultural Psychiatric Research Review*, 21, 275-276.
- Savage, G. (1987). Lentegour Hospital. (Letter). *South African Medical Journal*, 72, 294.
- Savage, M. (1979). Political and social constraints to effective medicine in South Africa. *The Leech*, 49(2), 36-39.
- Scheper-Hughes, N., & Lock, M. (1987). The mindful body: a prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly*, 2, 6-41.
- Schlebusch, L., Levin, A., & Moshal, M.G. (1981). The role of intelligence and depression in Indian and Black duodenal ulcer patients in South Africa. *South African Medical Journal*, 60, 613-614.

References

- Schoeman, J. B. (1985). Vera Bührmann's approach to cultural psychiatry. *Psychotherapeia and Psychiatry in Practice*, 36, 7-12.
- Schoeman, J. B. (1989). Psigopatologie by tradisionele swart Suid-Afrikaners. In D. A. Louw (Ed.). *Suid-Afrikaanse handboek van abnormale gedrag* (pp. 448-470). Johannesburg: Southern.
- Schoeman, J. B., Robertson, B., Lasisch, A. J., Bicha, E., & Westaway, J. (1989). Children and adolescents consulted at four psychiatric units in the Transvaal, and the Cape Province. *Southern African Journal of Child and Adolescent Psychiatry*, 1(2), 1-15.
- Scholtz, I. J. (1987). 'n Kruiskulturele ondersoek na bepaalde simptome van depressie. Unpublished master's dissertation, University of the Orange Free State, Bloemfontein.
- Schwartz, S., & Griffin, T. (1986). *Medical thinking: the psychology of medical judgement and decision making*. New York: Springer-Verlag.
- Schweitzer, R.D. (1977). *Categories of experience amoingst the Xhosa: A psychological study*. Unpublished master's dissertation, Rhodes University, Grahamstown.
- Schweitzer, R.D. (1980a). Indigenous therapy in South Africa. *Bulletin of the British Psychological Society*, 33, 278-281.
- Schweitzer, R.D. (1980b). Mental health in an African context: Alternative modes of service. In F. Wilson & G. Westcott (Eds.). *Economics of health in South Africa*, Vol. II (pp. 245-264). Johannesburg: Ravan.
- Schweitzer, R.D. (1983). *A phenomenological explication of dream interpretation among rural and urban Nguni people*. Unpublished doctoral dissertation, Rhodes University, Grahamstown.
- Schweitzer, R.D. (1985). Folk healing among the Xhosa speaking people. *Psychotherapeia and Psychiatry in Practice*, 36, 27-35.
- Seedat, A. (1984). *Crippling a nation: health in apartheid South Africa*. London: International Defence and Aid fro Southern Africa.
- Seedat, M., Cloete, N., & Schochet, I. (1988). Community psychology: panic or panacea? *Psychology in Society*, 11, 39-54.
- Seedat, Y.K. (1982a). Biosocial factors in hypertension in urban and rural Zulus. *South African Medical Journal*, 61, 99-102.
- Seedat, Y.K. (1982b). Lifestyle and disease: Hypertension and ischaemic heart disease in Indian people living in South Africa and in India. *South African Medical Journal*, 61, 965-967.
- Seedat, Y.K., Seedat, M.A., & Hackland, D.B. (1982). Prevalence of hypertension in the urban and rural Zulu. *Journal of Epidemiology and Community Health*, 36, 256-261.
- Seedat, Y.K., Seedat, M.A., & Nkomo, M.N. (1978). The prevalence of hypertension in the urban Zulu. *South African Medical Journal*, 53, 923-927.
- Seftel, H.C. (1977). Diseases in urban and rural Black populations. *South African Medical Journal*, 51, 121-123.
- Seftel, H.C. (1978). The rarity of coronary heart disease in South African Blacks. *South African Medical Journal*, 54, 99-105.
- Segal, I., & Hunt, J.A. (1975). The irritable bowel syndrome in the urban South African Negro. *South African Medical Journal*, 49, 1645-1646.

References

- Segal, I., Dubb, A.A., Ou Tim, L., Solomon, A., Sottomayor, M.C.C.C.G., & Zwane, E.M. (1978). Duodenal ulcer and working-class mobility in an African population in South Africa. *British Medical Journal*, 1, 469-472.
- Segal, I., & Ou Tim, L. (1979). The witchdoctor and the bowel. *South African Medical Journal*, 56, 308-310.
- Selzer, M. A. (1981). The role of the consultant in the case conference: some neglected aspects. *Psychiatry*, 44, 60-68.
- Separate Amenities Act *see* Republic of South Africa.
- Setiloane, G.M. (1987). African traditional views on death and dying. *South African Journal of Continuing Medical Education*, 5, 60-61.
- Shapiro, E. R., & Carr, A. W. (1987). Disguised countertransference in institutions. *Psychiatry*, 50, 72-82.
- Sharp, J. (1980). Can we study ethnicity? A critique of fields of study in South African anthropology. *Social Dynamics*, 6, 1-16.
- Sharp, J. (1981). The roots and development of *volkekunde* in South Africa. *Journal of Southern African Studies*, 8, 16-36.
- Sharp, J. (1988a). Introduction: constructing social reality. In E. Boonzaier & J. Sharp (Eds.). *South African keywords: uses and abuses of political concepts* (pp 1-16). Cape Town, South Africa: David Philip.
- Sharp, J. (1988b). Two worlds in one country: 'first world' and 'third world'. In E. Boonzaier & J. Sharp (Eds.). *South African keywords: uses and abuses of political concepts* (pp 111-121). Cape Town, South Africa: David Philip.
- Shaw, P. D. R. (1986). *A study of alienation and personality traits conducted among "Coloured" and white males in South Africa*. Unpublished master's dissertation, Rhodes University, Grahamstown.
- Shortt, S. E. D. (1986). *Victorian lunacy*. Cambridge: Cambridge University Press.
- Shuda, S., & Matthews, R.E. (1988). Kosmologiese betekenis van voedsel by swart psigiatriese pasiënte. *South African Journal of Ethnology*, 11, 174-181.
- Shweder, R. A. (1977). Likeness and likelihood in everyday thought: magical thinking in judgements about personality. *Current Anthropology*, 18, 637-658.
- Shweder, R. A. (1984). Anthropology's romantic rebellion against the Enlightenment, or There's more to thinking than reason and evidence. In R. A. Shweder & R. A. LeVine, (Eds.), *Culture theory: essays on mind, self and emotion* (pp. 27-66). Cambridge: Cambridge University Press.
- Shweder, R. A., & Bourne, E. (1982). Does the concept of the person vary cross-culturally? In A. Marsella & G. M. White (Eds.). *Cultural conceptions of mental health and therapy* (pp. 97-137). Dordrecht: Reidel.
- Shweder, R. A., & LeVine, R. A. (Eds.). (1984). *Culture theory: essays on mind, self and emotion*. Cambridge, Cambridge University Press.
- Silverman, D. (1987). *Communication and medical practice: social relations in the clinic*. London: Sage.
- Simkins, C. (1986). *Liberalism and the problem of power*. Hoernlé Memorial Lecture, South African Institute of Race Relations.
- Simons, R. C., & Hughes, C.C. (Eds.). (1985). *The culture-bound syndromes: folk illnesses of psychiatric and anthropological interest*. Dordrecht: Reidel.

References

- Sindzingre, N. (1988). Comments on five manuscripts. *Medical Anthropology Quarterly*, 2, 447-453.
- Singer, K. (1975). Depressive disorders from a transcultural perspective. *Social Science and Medicine*, 9, 289-301.
- Singer, M. (1989). The coming of age of critical medical anthropology. *Social Science and Medicine*, 28, 1193-1203.
- Singer, M., Davison, L., & Gerdes, G. (1988). Culture, critical theory and reproductive illness behavior in Haiti. *Medical Anthropology Quarterly*, 2, 370-386.
- Skinner, B. F. (1979). *The shaping of a behaviorist*. New York: Knopf.
- Skinner, D., & Swartz, L. (1989). The effect of a parent's detention on the preschool child: a preliminary South African study of caregivers' reports. *Journal of Child Psychology and Psychiatry*, 30, 243-259.
- Smith, J.L., Nel, P.D., & Joelson, L. (1987). Hypertension management in a Cape Peninsula coloured community: A retrospective medium-term assessment. *South African Medical Journal*, 72, 530-532.
- Snoyman, P. (1989). Dis-solution and re-solution of family dilemmas. In J. B. Mason & J. Rubenstein (Eds.), *Family therapy in South Africa today* (pp. 193-202). Congella, South Africa: South African Institute of Marital and Family Therapy.
- Society of Psychiatrists of South Africa. (1985). Position statement. *South African Medical Journal*, 67, 349.
- Soddy, A.G. (1972). *A comparison of patterns of mental illness amongst an urban White and Coloured population in Johannesburg*. Unpublished doctoral dissertation, University of the Witwatersrand.
- Sokhela, N. W. (1984). *Zulu indigenous practitioners' diagnostic and treatment methods*. Unpublished master's dissertation, University of Zululand, Zululand.
- Solomons, K. (1980). The development of mental health facilities in South Africa 1916-1976. In F. Wilson & G. Westcott (Eds.), *Economics of health in South Africa, Vol. II* (pp. 265-311). Johannesburg: Ravan.
- Solomons, K. (1988). A contribution to a theory of the dynamic mechanisms of Post-traumatic Stress Disorder in South African detainees. *Psychology in Society*, 11, 18-30.
- Solomons, K., & Neppe, V. M. (1989). Cannabis - its clinical effects. *South African Medical Journal*, 76, 102-104.
- Soul, T.V. (1975). *A comparative study of rural and urban Africans on their attitude towards Amagqira (witchdoctors)*. Unpublished master's dissertation, University of Fort Hare, Alice.
- South African Institute of Race Relations (SAIRR) (1984). *Survey of Race Relations in South Africa 1983*. Johannesburg: S.A.I.R.R.
- South African Institute of Race Relations (SAIRR) (1985). *Race Relations Survey 1984*. Johannesburg: SAIRR.
- South African Institute of Race Relations (SAIRR) (1988). *Race relations survey 1987/88*. Johannesburg: SAIRR.
- South African Medical Journal (1979). Psychiatry for Africa. (Editorial). *South African Medical Journal*, 55, 149-150.
- Sparr, L. F., Gordon, G. H., Hickam, D. H., & Girard, D. E. (1988). The doctor-patient relationship during medical internship: the evolution of dissatisfaction. *Social Science and Medicine*, 26, 1095-1101.

References

- Spiegel, A. D., & Boonzaier, E. (1988). Promoting tradition: images of the South African past. In E. Boonzaier & J. Sharp (Eds). *South African keywords: the use and abuse of political concepts* (pp. 40-57). Cape Town: David Philip.
- Spinks, P.M. (1980). *The development of an anxiety scale for a population of South African Indians*. Unpublished master's dissertation, University of Natal, Durban.
- Spinks, P.M. (1982). Anxiety responses in a sample of South African Indians. *Motivation & Emotion*, 6, 79-93.
- Spinks, P.M. (1983). Antecedents of anxiety in an ethnic minority. *Journal of Southern African Studies*, 121, 267-268.
- Stainback, S., & Stainback, W. (1984). Broadening the research perspective in special education. *Exceptional Children*, 50, 400-408.
- Stanton, A. H., & Schwartz, M. S. (1954). *The mental hospital*. New York: Basic Books.
- Stanton, E. (1970). *Clients come last: volunteers and welfare organizations*. Beverley Hills: Sage.
- Stein, H. F. (1986). 'Sick people' and 'trolls': a contribution to the understanding of the dynamics of physician explanatory models. *Culture, Medicine and Psychiatry*, 10, 221-229.
- Stoch, M.B., Smythe, P.M., Moodie, A.D., & Bradshaw, D. (1982). Psychosocial outcome and CT findings after gross undernourishment during infancy: A 20-year developmental study. *Developmental Medicine and Child Neurology*, 24, 419-436.
- Stone, A., Pinder-Hughes, C., Spurlock, J., & Weinberg, D. (1979). *see* Committee to visit South Africa.
- Stott, N.C.H., & Browne, W.M. (1973). Do witchdoctors practise clinical pattern recognition? *South African Medical Journal*, 47, 334-335.
- Stover, E., & Nightingale, E. O. (Eds.). (1985). *The breaking of bodies and minds. Torture, psychiatric abuse and the health professions*. New York: W. H. Freeman and Company.
- Straker, G. (1989). From victim to villain: a 'slight' of speech? Media representations of township youth. *South African Journal of Psychology*, 19, 20-27.
- Straker, G., & the Sanctuaries Counselling Team (1987). The continuous traumatic stress syndrome: the single therapeutic interview. *Psychology in Society*, 8, 48-78.
- Strebel, A. (1983a). Appropriate psychology for Southern Africa? *Matlasedi Education Bulletin*, 2(2), 1-5.
- Strebel, A. (1983b, September). *Training implications for the counselling of the culturally different*. Paper presented at the First Conference of the Psychological Association of South Africa, Pietermaritzburg.
- Strong, P. (1979). *The ceremonial order of the clinic*. London: Routledge and Kegan Paul.
- Sullivan, M. (1986). In what sense is contemporary medicine dualistic? *Culture, Medicine and Psychiatry*, 10, 331-350.
- Suttner, R., & Cronin, J. (1986). *Thirty years of the freedom charter*. Johannesburg: Ravan.
- Swartz, L. (1979). The development of Harré's blueprint. Unpublished paper, Department of Psychology, University of Cape Town.
- Swartz, L. (1982). *Psychological aspects of bulimia nervosa in women*. Unpublished master's dissertation, University of Cape Town, Cape Town.

References

- Swartz, L. (1983). From operationism to cultural design: an approach to Skinner's development. *South African Journal of Psychology*, 13, 51-56.
- Swartz, L. (1984). *Models of cross-cultural psychiatric research: Some implications for South Africa*. Paper presented at the International Conference on Research Methodology in the Social Sciences, University of Durban-Westville, Durban.
- Swartz, L. (1985a). Anorexia nervosa as a culture-bound syndrome. *Social Science and Medicine*, 20, 725-730.
- Swartz, L. (1985b). Issues for cross-cultural Psychiatric research in South Africa. *Culture, Medicine and Psychiatry*, 9, 59-74.
- Swartz, L. (1985c). Is thin a feminist issue? *Women's Studies International Forum*, 8, 429-437.
- Swartz, L. (1986a). Carl Rogers in South Africa: the issue of silence. *Psychology in Society*, 5, 139-143.
- Swartz, L. (1986b). *Some issues about professionalism in current South African psychology*. Paper presented at Africa seminar, Centre for African Studies, University of Cape Town, Cape Town.
- Swartz, L. (1986c). Transcultural psychiatry in South Africa. Part I. *Transcultural Psychiatric Research Review*, 23, 273-303.
- Swartz, L. (1987a). Illness negotiation: the case of eating disorders. *Social Science and Medicine*, 24, 613-618.
- Swartz, L. (1987b). Transcultural psychiatry in South Africa. Part II. *Transcultural Psychiatric Research Review*, 24, 5-30.
- Swartz, L. (1988). Some comments on the draft ethical code for clinical psychologists. *South African Journal of Psychology*, 18, 17-20.
- Swartz, L., Ben-Arie, O., & Teggin, A.F. (1985). Subcultural delusions and hallucinations: Comments on the Present State Examination in a multi-cultural context. *British Journal of Psychiatry*, 146, 391-394.
- Swartz, L., Elk, R., Teggin, A.F., & Gillis, L.S. (1983). Life events in Xhosas in Cape Town. *Journal of Psychosomatic Research*, 27, 223-231.
- Swartz, L., & Foster, D. (1984). Images of culture and mental illness: South African psychiatric approaches. *Social Dynamics*, 10, 17-25.
- Swartz, L., Gibson, K., & Swartz, S. (in press). State violence in South Africa and the development of a progressive psychology. To appear in N. C. Manganyi & A. du Toit (Eds.). *Political violence in South Africa*. London; Macmillan.
- Swartz, L., & Levett, A. (1989). Political repression and children in South Africa: the social construction of damaging effects. *Social Science and Medicine*, 28, 741-750.
- Swartz, S. (1988). *Applied psycholinguistics*. Unpublished course reader, Department of Psychology, University of Cape Town.
- Swartz, S. (1989). *Applied psycholinguistics*. Unpublished course reader, Department of Psychology, University of Cape Town.
- Swartz, S., Dowdall, T., & Swartz, L. (1986). Clinical psychology in Cape Town and the 1985 crisis. *Psychology in Society*, 5, 131-138.
- Swartz, S., & Swartz, L. (1982). Harré's *Social being*: the connection with structuralism. *Journal for the Theory of Social Behaviour*, 12, 201-221.

References

- Swartz, S., & Swartz, L. (1986). Negotiation of professional role: Workshops with preschool teachers, Cape Town 1985-1986. *Proceedings of the Organization for Appropriate Social Services 'Apartheid and Mental Health' Conference* (pp. 61-66). Johannesburg: OASSSA.
- Swartz, S., & Swartz, L. (1987). Talk about talk: Metacommentary and context in the analysis of psychotic discourse. *Culture, Medicine and Psychiatry*, 11, 395-416.
- Szasz, T. (1961). *The myth of mental illness*. New York: Hoeber and Harper.
- Szasz, T. (1971). *The manufacture of madness*. London: Routledge and Kegan Paul.
- Tau, J. (1989). Family therapy: is it relevant to the experience of South Africa's third world communities? In J. B. Mason & J. Rubenstein (Eds.), *Family therapy in South Africa today* (pp. 37-39). Congella, South Africa: South African Institute of Marital and Family Therapy.
- Taussig, M. T. (1980). Reification and the consciousness of the patient. *Social Science and Medicine*, 14B, 3-13.
- Teggin, A.F., Elk, R., Ben-Arie, O., & Gillis, L.S. (1985). A comparison of PSE CATEGO 'S' Schizophrenia in three population groups: Psychiatric manifestations. *British Journal of Psychiatry*, 147, 683-687.
- The Lancet. (1977). Apartheid and mental health care (Editorial). *The Lancet*, 2, 491.
- Thornton, R. (1988). Culture: a contemporary definition. In E. Boonzaier & J. Sharp (Eds.), *South African keywords: the use and abuse of political concepts* (pp. 1-16). Cape Town: David Philip.
- Thornton, R. (1989, January). *Recent trends in the theory of culture*. Paper presented at the 'Knowledge and Method' Conference on the Philosophy and Methodology of the Human Sciences. Human Sciences Research Council, Pretoria.
- Thornton, R., & Ramphele, M. (1988). The quest for community. In E. Boonzaier & J. Sharp (Eds.), *South African keywords: the use and abuse of political concepts* (pp. 17-28). Cape Town: David Philip.
- Toker, E. (1966). Mental illness in the white and bantu populations of the Republic of South Africa. *American Journal of Psychiatry*, 123, 55-63.
- Totman, R. (1979). *Social causes of illness*. New York: Pantheon.
- Toulmin, S. (1978). Psychic health, mental clarity, self-knowledge and other virtues. In H. T. Engelhardt, Jr & S. F. Spicker (Eds.), *Mental health: philosophical perspectives* (pp. 55-70). Dordrecht: Reidel.
- Townsend, J. M. (1978). Cultural conceptions of the role of the psychiatrist in Germany and America. *International Journal of Social Psychiatry*, 24, 250-258.
- Trostle, J. A. (1988). Medical compliance as ideology. *Social Science and Medicine*, 27, 1299-1308.
- Trostle, J. A., Hauser, W. A., & Susser, I. (1983). The logic of noncompliance: management of epilepsy from the patient's point of view. *Culture, Medicine and Psychiatry*, 7, 35-56.
- Turner, B. S. (1987). *Medical power and social knowledge*. Beverley, Hills, California: Sage.
- Turner, V. (1987/1967). Betwixt and between: the liminal period in rites of passage. In L. C. Mahdi, S. Foster, & M. Little. (Eds.), *Betwixt and between: patterns of masculine and feminine initiation* (pp. 3-19). La Salle, Illinois: Open Court. (Reprinted from *The forest of symbols*. Ithaca, NY: Cornell.
- Turshen, M. (1986). Health and human rights in a South African Bantustan. *Social Science and Medicine*, 22, 887-892.

References

- Turton, R.W. (1986a). Bourgeois counselling and working-class clients: Some problems and implications. *Psychology in Society*, 6, 85-100.
- Turton, R.W. (1986b). *Stressful life events and illness among urban blacks*. Unpublished master's dissertation, University of Witwatersrand, Johannesburg.
- Uys, L. (1986). Perceptions of health and illness, and related practices among the urban black population of Mangaung (Bloemfontein). *Curationis*, 9(4), 28-33.
- Van Binsbergen, W. (1988). The land as body: an essay on the interpretation of ritual among the Manjaks of Guinea-Bissau. *Medical Anthropology Quarterly*, 2, 386-401.
- Van der Burgh, C. (1983a). *Views of White, Coloured and Indian South Africans on mental illness and the mentally ill*. Pretoria: Institute for Sociological and Demographic Research, Human Sciences Research Council (Publication S-N-225).
- Van der Burgh, C. (1983b). Drinking patterns in multiethnic South African society. *Journal of Studies on Alcohol*, 44, 446-459.
- Van Der Hoofdt, G.A. (1979). *De Malopodans: een transcultureel-psychiatrische studie*. Doctoral dissertation, Rijksuniversiteit of Leiden (published by Rodopi).
- Van Der Hoofdt, G.A. (1980). Some possibly paranormal aspects of Malopo dancing. *Parapsychological Journal of South Africa*, 1, 32-43.
- Van Der Hoofdt, G.A., & Erasmus, J.A.K. (1976). Malopo, 'n psigiatrisie sindroom? *Geneeskunde*, 18, 1-7.
- Van der Merwe, I.J., & Zietsman, H.L. (1982). Ruimtelike patrone van geestesiektes in Kaapstad. *South African Geographer*, 10, 9-18.
- Van der Spuy, H.I.J., & Shamley, D.A.F. (Eds), (1978). *The psychology of apartheid: A psychosocial perspective on South Africa*. Washington: University Press of America.
- Van Rensburg, H.C.J., & Mans, A. (1982). *Profile of disease and health care in South Africa*. Pretoria: Academia.
- Van Schalkwyk, T. A., Sexton, P. A., & Robertson, L. (1989). *Language barriers in the psychiatric emergency unit*. Unpublished paper, 'De Hoop' Hospital.
- Van Zijl, J.C. (1980). *Counselling-seeking: A cross-cultural study conducted at three South African universities*. Unpublished doctoral dissertation, University of Natal (Pietermaritzburg).
- Venter, A.M. (1977). *Enkele persoonlikheidskenmerke by essensieele hipertensie-Kleurlingvroue*. Unpublished master's dissertation, Stellenbosch University, Stellenbosch.
- Villa-Vicencio, C. (1987). *Theology and violence: the South African debate*. Cape Town: David Philip.
- Vogelman, L. (1986). Apartheid and mental health. *Proceedings of the Organization for Appropriate Social Services 'Apartheid and Mental Health' Conference* (pp. 3-12). Johannesburg: OASSSA.
- Waitzkin, H. (1989). A critical theory of medical discourse: ideology, social control, and the processing of social context in medical encounters. *Journal of Health and Social Behavior*, 30, 220-239.
- Wajzman, M. (1986). *An exploratory study of the comparison of Western and indigenous healing approaches to the mental health of the black mine workers in the Transvaal*. Unpublished master's dissertation, University of the Witwatersrand, Johannesburg.

References

- Walker, A.R.P. (1976). Measuring emotional stress in Africa. *South African Medical Journal*, 50, 536.
- Washburn, W. E. (1987). Cultural relativism, human rights, and the AAA. *American Anthropologist*, 89, 939-943.
- Wassermann, H.P. (1988). Apartheid and health services. (Letter). *South African Medical Journal*, 73, 783.
- Watts, H.L. (1980). Some reactions to illness in urban Black and Indian families in Durban - a summary of an exploratory study. *South African Medical Journal*, 57, 589-591.
- Webster, E. (1986). The role of social scientists in the current South African crisis. *Proceedings of the Organization for Appropriate Social Services 'Apartheid and Mental Health' Conference* (pp. 38-43). Johannesburg: OASSSA.
- Weiss, E. (1984). *Amafufunyane*. Unpublished paper. University of Cape Town.
- Weiss, M. G., & Kleinman, A. (1988). Depression in cross-cultural perspective: developing a culturally informed model. In P. R. Dasen, J. W. Berry, & N. Sartorius, (Eds.) *Health and cross-cultural psychology: toward applications* (pp.179-206). Beverly Hills: Sage.
- Welman, M. (1989). Personal communication.
- Wessels, W. H. (1976). Symptomatology of schizophrenia in the Bantu. *Psychotherapeia*, 2(4), 5-7.
- Wessels, W. H. (1984, July). *Transcultural aspects of psychiatry*. Proceedings of Interdisciplinary symposium of the College of Medicine of South Africa.
- Wessels, W. H. (1985a). Cultural psychiatry: theory and practice. *South African Journal of Continuing Medical Education*, 3, 3-36.
- Wessels, W. H. (1985b). The traditional healer and psychiatry. *Australian and New Zealand Journal of Psychiatry*, 19, 283-286.
- West, M.E. (1975a). *Bishops and prophets in a Black city: African independent churches in Soweto, Johannesburg*. Cape Town: David Philip. London: Rex Collings.
- West, M.E. (1975b). The shades come to town: Ancestors and urban independent churches. In M.G. Whisson & M. West (Eds), *Religion and social change in South Africa* (pp. 185-206). Cape Town: David Philip. London: Rex Collings.
- West, M. E., & Boonzaier, E. (1989). population groups, politics and medical science. *South African Medical Journal*, 72, 185-186.
- White, D. H. (1982). *The effects of job stress in the South African gold mining industry*. Unpublished doctoral dissertation, University of South Africa, Pretoria.
- WHO see World Health Organization
- Wilson, F., & Ramphela, M. (Eds.). (1988). *Uprooting poverty: the South African challenge*. Johannesburg: Ravan.
- Wilson, F., & Westcott, G. (Eds.). (1980). *Economics of health in South Africa* (2 vols.). Johannesburg: Ravan.
- Wilson, M. (1980). Can traditional diviners and herbalists, and modern healers contribute to community health? In F. Wilson & G. Westcott (Eds). *Economics of health in South Africa Vol. II* (pp. 338-342). Johannesburg: Ravan.

References

- Wing, J. K. (1978). *Reasoning about madness*. Oxford: Oxford University Press.
- Wing, J. K., Bebbington, P., & Robins, L. N. (Eds.). (1981). *What is a case? The problem of definition in psychiatric community surveys*. London: Grant McIntyre.
- Wing, J. K., Cooper, J. E., & Sartorius, N. (1974). *The measurement and classification of psychiatric symptoms: an instruction manual for the PSE and Catego Program*. London: Cambridge University Press.
- Winnicott, D. (1984). *Playing and reality*. Harmondsworth: Penguin.
- Wober, M. (1975). *Psychology in Africa*. London: International African Institute.
- Wood, N., & Wassenaar, D. R. (1989). Family characteristics of Indian parasuicide patients: a controlled study. *South African Journal of Psychology*, 19, 172-184.
- Wood, R. (1989). *Workshops with primary school teachers in Guguletu as an intervention strategy in some common emotional and behavioural problems*. Unpublished master's dissertation, University of Cape Town, Cape Town.
- World Health Organization (WHO). (1973). *International pilot study of schizophrenia*. Geneva: WHO.
- World Health Organization (WHO). (1977). *Apartheid and mental health care: A preliminary review*. Publication MNH/77.5 Geneva: World Health Organization.
- Wright, P. W. G., & Treacher, A. (Eds.). *The problem of medical knowledge: examining the social construction of medicine*. Edinburgh: University of Edinburgh Press.
- Yach, D. (1988). Tuberculosis in the Western Cape region of South Africa. *Social Science and Medicine*, 27, 683-691.
- Yager, J. (1974). A survival guide for psychiatric residents. *Archives of General Psychiatry*, 30, 494-499.
- Young, A. (1980). The discourse on stress and the reproduction of conventional knowledge. *Social Science and Medicine*, 14B, 133-146.
- Young, A. (1982). The anthropologies of illness and sickness. *Annual Review of Anthropology*, 11, 257-285.
- Young, A. (1987). How medicine tamed life (Review of R. Arney & B. Bergen (1984). *Medicine and the management of living: taming the last great beast*.) *Culture, Medicine and Psychiatry*, 11, 107-121.
- Young, A. (1988). Unpacking the demoralisation thesis. *Medical Anthropology Quarterly*, 2, 3-16.
- Young, K. (1989). Disembodiment: the phenomenology of the body in medical examinations. *Semiotica*, 73, 43-66.
- Zola, I. K. (1981). Structural constraints in the doctor-patient relationship: the case of non-compliance. In L. Eisenberg & A. Kleinman (Eds.), *The relevance of social science for medicine* (pp. 241-252). Dordrecht: Reidel.
- Zwarenstein, M., & Bradshaw, D. (1989). An overview of health status and health care provision in South Africa. In C. P. Owen (Ed.), *The case for a national health service* (pp. 77-88). Department of Adult Education and Extra-Mural Studies and the National Medical and Dental Association (Western Cape), University of Cape Town.
- Zwi, A. (1987). The political abuse of medicine and the challenge of opposing it. *Social Science and Medicine*, 25, 649-657.

References

- Zwi, A., Fonn, S., & Steinberg, M. (1988). Occupational health and safety in South Africa: the perspectives of capital, state and unions. *Social Science and Medicine*, 27, 691-702.
- Zwi, A., Marks, S., & Andersson, N. (1988). Introduction. Health, apartheid and the Frontline States. *Social Science and Medicine*, 27, 661-666.
- Zwi, A., & Saunders, L.D. (Eds.). (1986). *Towards health, care for all: NAMDA Conference '85*. Johannesburg: NAMDA.

APPENDICES

Appendix	Short title	Page
A	Units in the hospital system	390
B	Registrar placements	393
C	Letter sent to registrars	398
D	Key to Present State Examination symptoms used in vignette construction	399
E	Complete tables for registrars' ranking of vignettes	402

Appendix A

A brief outline of units in the hospital system

The psychiatric hospital system through which registrars from the department of psychiatry under study rotate comprises a number of units, described briefly in the table below. All names of units have been changed to protect confidentiality.

Unit	Capacity	Brief description
1. De Hoop General Hospital:		
Psychiatric Casualty	<i>10 beds, all races</i>	'Clearing house' unit, point of entry into hospital system for most new patients destined for all units below
E55	<i>23 beds, all races, historically whites only and still mainly whites</i>	Psychotherapeutic unit, considered the most prestigious in the hospital system
S56	<i>14 day patients, all races, historically whites only and still mainly whites</i>	Psychotherapeutic day centre of similar organisation to E55, caters for adolescents and young adults.
2. Units under the direct administrative control of De Hoop but situated elsewhere:		
Adam Jones Hospital	<i>20 beds, all races, historically whites only and still mainly whites</i>	Alcohol (primarily) and drug treatment facility
Frankville (Psychiatry section)	<i>16 beds, all races, historically coloureds only and still mainly coloureds</i>	Psychotherapeutic unit

Appendix A

Frankville (Alcohol section)	<i>12 beds, all races, historically coloureds only and still mainly coloureds</i>	Alcohol (primarily) and drug treatment facility
Parent and children's centre	<i>Out-patient service with wide catchment area</i>	Child and family therapy service with some community clinics

3. Eagle's Nest Hospital:

Orange Grove side	<i>493 beds, whites only, has been the occasional coloured or Black patient</i>	Usual range of services of large psychiatric hospital - admission and chronic units, geriatrics, forensics
Percelia side	<i>Official bed capacity 400, actual number of beds closer to 500, Blacks only</i>	Usual range of services of large psychiatric hospital - admission and chronic units, geriatrics, forensics

4. Spring Valley Hospital:

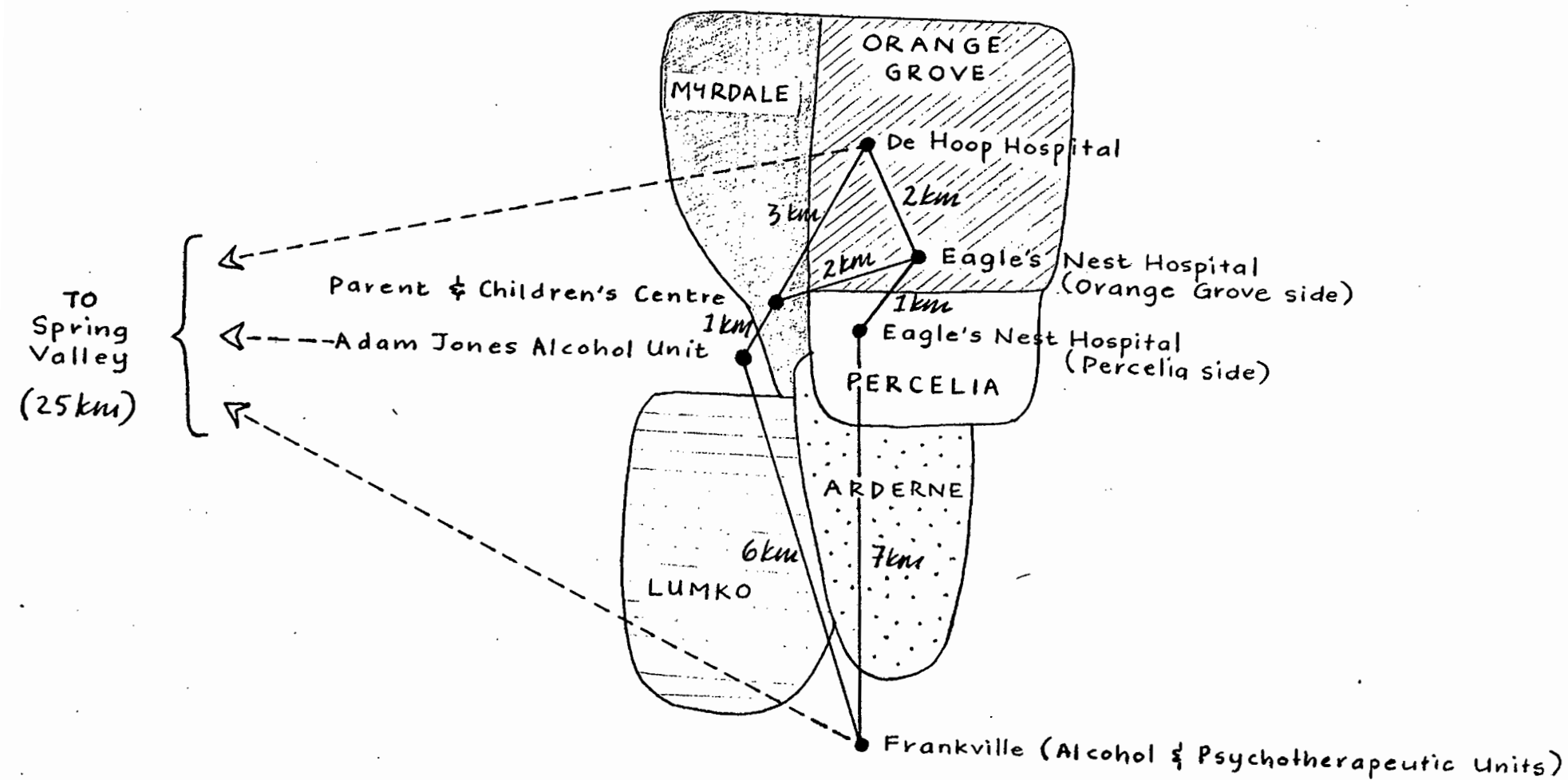
Spring Valley	<i>655 beds, originally all for coloureds but has open policy; particular units such as drug unit have substantial proportion of other race patients</i>	Usual range of services of large psychiatric hospital - admission and chronic units, geriatrics, forensics
----------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------

Note: The units under the aegis of De Hoop Hospital, all of which are supposedly for all races, have been opened to all over the past two years in accordance with the university's policy on racial desegregation and in defiance of implicit state policy. It appears however that by and large the status quo with respect to racial categories of patient has been maintained. Eagle's Nest, which falls under state as opposed to the provincial health authority controlling De Hoop remains with very rare exceptions rigidly segregated. Spring Valley is administered by the (coloured) House of Representatives but has had an official open policy since its inception. It is nonetheless regarded as a 'coloured' institution.

The figure overleaf gives an indication of the distances of the various units from one another and their location relative to the suburbs used for the vignette study reported in Part 3 of the dissertation. It should be noted that all units with the exception of Frankville

Appendix A

and Spring Valley are situated in white areas (as so designated by the Group Areas Act of 1950). It is a function of the age of Eagle's Nest (over 100 years) that the Black side is located in a white Group Area. Spring Valley is situated in a comparatively new dormitory area set aside for coloureds far, as can be seen, from the other units, all of which are close to the city centre (under 10km away).



SCHEMATIC REPRESENTATION OF APPROXIMATE LOCATION OF UNITS IN THE HOSPITAL SYSTEM, AND THEIR RELATIONSHIP TO SUBURBS USED FOR THE VIGNETTES

Appendix B

Previous and current placements of registrars at the time of the study

The placement records of all registrars from the longest serving to the shortest are recorded here. For reasons of confidentiality, the registrar list is not organised here by the numbering system used in the text as individual placement records could serve to identify registrars. The identification here of registrars by letter of the alphabet is simply by length of service.

Dr A:

01.02.85 - 31.07.85	Eagle's Nest - Black side
05.08.85 - 02.02.86	Eagle's Nest - Black side
03.02.86 - 03.08.86	Eagle's Nest - white side
04.08.86 - 01.02.87	Therapeutic unit - De Hoop
02.02.87 - 02.08.87	Adam Jones alcohol unit
03.08.87 - 31.01.88	Psychiatric Casualty - De Hoop
02.02.88 - 31.07.88	Parent and children centre
01.08.88 - 31.01.89	Eagle's Nest - white side

Dr B:

01.03.85 - 04.08.85	Eagle's Nest - Black side
05.08.85 - 02.02.86	Eagle's Nest - Black side
03.02.86 - 03.08.86	Frankville Therapeutic unit
04.08.86 - 01.02.87	Psychiatric Casualty - De Hoop
02.02.87 - 02.08.87	Therapeutic unit - De Hoop
03.08.87 - 31.01.88	Spring Valley

Appendix B

02.02.88 - 31.07.88 Parent and children centre

01.08.88 - 31.01.89 Eagle's Nest - Black side

Dr C:

01.04.85 - 31.07.87 Eagle's Nest - geriatric wards

05.08.85 - 02.02.86 Eagle's Nest - Black side

03.02.86 - 03.08.86 Adam Jones alcohol unit

04.08.86 - 01.02.87 Eagle's Nest - white side

02.02.87 - 02.08.87 Frankville Therapeutic unit

03.08.87 - 31.01.88 Psychiatric Casualty - De Hoop

01.02.88 - 31.07.88 Parent and children centre

01.08.88 - 31.01.89 Eagle's Nest - forensic units

Dr D:

07.07.86 - 03.08.86 Spring Valley

04.08.86 - 31.01.87 Eagle's Nest - Black side

01.02.87 - 02.08.87 Eagle's Nest - white side

03.08.87 - 31.01.88 Therapeutic unit - De Hoop

01.02.88 - 31.07.88 Psychiatric Casualty - De Hoop

01.08.88 - 31.01.89 Parent and children centre

Dr E:

07.07.86 - 31.10.86 Spring Valley

01.11.86 - 31.01.87 Psychiatric Casualty - De Hoop

01.02.87 - 02.08.87 Frankville Therapeutic unit

03.08.87 - 31.01.88 Frankville Therapeutic unit

Appendix B

01.02.88 - 31.07.88	Spring Valley
01.08.88 - 31.01.89	Parent and children centre

Dr F:

01.11.86 - 31.01.87	Eagle's Nest - geriatric wards
01.02.87 - 02.08.87	Eagle's Nest - white side
03.08.87 - 31.01.88	Eagle's Nest - Black side
01.02.88 - 31.07.88	Frankville Therapeutic unit
01.08.88 - 31.01.89	Psychiatric Casualty - De Hoop

Dr G:

01.02.87 - 02.08.87	Eagle's Nest - white side
03.08.87 - 02.08.87	Eagle's Nest - forensic units
01.02.88 - 31.07.88	Therapeutic unit - De Hoop
01.08.88 - 31.08.89	Psychiatric Casualty - De Hoop
01.02.89 - 31.07.89	Parent and children centre

Dr H:

01.02.87 - 02.08.87	Eagle's Nest - Black side
03.08.87 - 31.01.88	Eagle's Nest - white side
01.02.88 - 31.07.88	Adam Jones alcohol unit
01.08.88 - 31.01.89	Frankville Therapeutic unit

Dr I:

01.03.87 - 02.08.87	Eagle's Nest - geriatric wards
---------------------	--------------------------------

Appendix B

03.08.87 - 31.01.88	Eagle's Nest - Black side
01.02.88 - 31.07.88	Eagle's Nest - forensic units
01.08.88 - 31.01.89	Therapeutic unit - De Hoop

Dr J:

01.05.87 - 02.08.87	Eagle's Nest - Black side
03.08.87 - 31.01.88	Frankville alcohol unit
01.02.88 - 31.07.88	Psychiatric Casualty - De Hoop
01.08.88 - 31.01.89	Eagle's Nest - white side

Dr K:

01.07.87 - 31.01.88	Spring Valley
01.02.88 - 31.07.88	Eagle's Nest - Black side
01.08.88 - 31.01.89	Eagle's Nest - forensic units

Dr L:

01.07.87 - 31.01.88	Eagle's Nest - white side
01.02.88 - 31.07.88	Frankville alcohol unit
01.08.88 - 31.01.89	Eagle's Nest - Black side

Dr M:

01.10.87 - 31.01.88	Eagle's Nest - geriatric wards
01.02.88 - 31.07.88	Eagle's Nest - Black side
01.08.88 - 31.01.89	Adam Jones alcohol unit

Appendix B

Dr N:

01.01.88 - 31.07.88	Eagle's Nest - Black side
01.08.88 - 31.01.89	Eagle's Nest - geriatric wards

Dr O:

01.01.88 - 31.07.88	Eagle's Nest - white side
01.08.88 - 31.01.89	Frankville alcohol unit

Dr P:

01.02.88 - 31.07.88	Spring Valley
01.08.88 - 31.01.89	Eagle's Nest - white side

Dr Q:

01.03.88 - 31.07.88	Spring Valley
01.08.88 - 31.01.89	Eagle's Nest - Black side

Dr R:

01.05.88 - 31.07.88	Eagle's Nest - forensic units
01.08.88 - 31.01.89	Spring Valley

Appendix C

Text of letter sent to psychiatric registrars

(altered to disguise identifying data)

Dear

As you may know, I am currently conducting research into aspects of psychiatric practice in [city].

Psychiatric registrars carry the bulk of psychiatric cases in your system, and your opinions therefore are crucial to any understanding I may develop of your local practices. I am writing to you and to all the other registrars to ask your permission to interview you individually for purposes of my research. Should you be agreeable, I shall be contacting you within the next few weeks to set up a meeting at a time and place convenient to you. I will be able to explain more about what I am doing when I speak to you, but I can assure at this stage of complete anonymity and confidentiality in my reporting of data.

If you feel at this stage that you would be unwilling to participate in the study, or have any queries at all, please feel free to contact me. I am in the Psychology Department at the University of Cape Town and my telephone numbers are (w) 021-650-3437 and (h) 021-686-6376. We can also discuss any questions that you may have when I contact you or at our interview, should you agree to participate.

I hope that with the assistance of people such as you this study will help in the further development of South African psychiatric practice. The results will, of course, be made available to you when the study has been completed, should you be interested.

Thanks very much. I'll be in contact soon.

Yours sincerely

Leslie Swartz
Lecturer/Clinical Psychologist

Appendix D

Key to Present State Examination (PSE) (eighth edition) symptoms and syndromes used in the construction of the vignette studies used in Part 3 of the dissertation

Note: all references are to Wing, Cooper & Sartorius (1974)

Mr A

<i>Text of the vignette</i>	<i>PSE Symptom</i>	<i>PSE Syndrome</i>
<i>Mr A is a twenty-five year old man living in «suburb». He is admitted to [Psychiatric Casualty] with the following symptoms, as reported by his family. For the past two weeks he has been 'in a funny mood'.</i>		
<i>He has appeared very happy,</i>	41. expansive mood/ subjective euphoria	HM. Hypomania
<i>saying that he's full of exciting ideas,</i>	42. ideomotor pressure	HM. Hypomania
<i>but he has also been accusing people of wanting to poison him</i>	74. delusions of persecution	PE. Delusions of Persecution
<i>and of being able to read his thoughts.</i>	59. thoughts read	SF. Sexual and Fantastic Delusions
<i>When questioned about what has been happening to him he has claimed that there is witchcraft going on and he may be being hypnotised but he is not sure by whom.</i>	79. delusional explanation (paranormal phenomena)	SF. Sexual and Fantastic Delusions
<i>On admission to [Psychiatric Casualty] he is fidgety, restless and paces up and down,</i>	111. agitation on examination	AG. Agitation
<i>and when questioned is unable to say where he is.</i>	(disorientation - see note below)	(Disorientation - see note below)

Note: the symptom of disorientation does not appear in the PSE, and was added by Rottanburg (1982). The symptoms in this vignette correspond directly to those recorded by Rottanburg for patients with high levels of cannabinoids in their urine.

Appendix D

Mr M

Mr M is a twenty-five year old man living in «suburb». He is admitted to [Psychiatric Casualty] complaining that he has trouble thinking clearly.

19. inefficient thinking*

SD. Simple Depression*

He says that he cannot make decisions about even the smallest task, no matter how hard he tries.

19. inefficient thinking**

SD. Simple Depression**

When asked why this is happening to him, he says that it may be that he is troubled by thoughts which are not his own.

55. thought insertion

NS. Nuclear Syndrome

He is concerned that he may have committed a crime

88. delusions of guilt

DD. Depressive Delusions and Hallucinations

but also entertains the possibility that a spirit has entered his body and may be responsible for his actions.

81. delusions of alien penetration

NS. Nuclear Syndrome

His family reports that he does not sleep at night

**35. delayed sleep/
37. early waking**

WO. Worrying, etc./
OD. Other Symptoms of Depression

and has lost weight

?34. loss of appetite

OD. Other Symptoms of Depression

There seems to have been a change in him over the past few weeks as he always used to follow serials on the radio but has not put the radio on during this time, claiming that he is not interested.

**20. poor concentration/
22. loss of interest*****

IC. Loss of Interest and Concentration***

*Note: Although the text of this part of the vignette can be read as 'inefficient thinking' as stated, the sentence was worded deliberately to recall the general prompt question for thought reading, insertion, echo and broadcast ('Can you think quite clearly or is there any interference with your thoughts?' - Wing et al, 1974, p. 207).

**Note: This was worded to introduce a suggestion of possible ambivalence - not a PSE symptom but one historically associated with schizophrenia.

***Note: This was worded to introduce the suggestion of delusions of reference (Symptom 72; Syndrome RE).

Mr X

Mr X is a twenty-five year old man living in «suburb». He is referred to [Psychiatric Casualty] from [Medical Casualty] with the complaint that he is difficult to examine physically as he seems very uncooperative. When asked to stand up, for example, he sits down, and vice versa.

[Medical Casualty] has not been given any reason for his admission and he appears physically healthy. When asked by the registrar on duty to describe what has been happening to him he says this is not necessary as the registrar can read his mind.

He looks rather puzzled

and seems to be preoccupied with something but is evasive,

though he admits that he feels he can carry on conversations with spirits, whom he can see.

119. catatonic movements: negativism

59. thoughts being read

126. perplexity

94. evasiveness

64. dissociative hallucinations

CS. Catatonic Syndrome

SF. Sexual and Fantastic Delusions

NP. Non-specific Psychosis

NP. Non-specific Psychosis

HT. Hysteria/ SC. 'Subcultural' Delusions or Hallucinations (depending on whether the dissociation is regarded as 'culturally acceptable')

Appendix E

Complete tables for registrars' ranking of vignettes

(for interpretation and key, see Chapter 11)

Certainty of diagnosis

	AA	AL	AM	MA	ML	MM	XA	XL	XM	Total
AA	■				-1	0		2	-3	-2
AL		■		-1		-2	-1		-1	-5
AM			■	-3	0		0	0		-3
MA		1	3	■				3	-2	5
ML	1		0		■		0		0	1
MM	0	2				■	2	2		6
XA		1	0		0	-2	■			-1
XL	-2		0	-3		-2		■		-7
XM	3	1		2	0				■	6

Adequacy of care

	AA	AL	AM	MA	ML	MM	XA	XL	XM	Total
AA	■				2	-2		3	-1	2
AL		■		-2		-3	-2		0	-7
AM			■	1	1		1	2		5
MA		2	-1	■				2	1	4
ML	-2		-1		■		-1		-2	-6
MM	2	3				■	3	3		11
XA		2	-1		1	-3	■			-1
XL	-3		-2	-2		-3		■		-10
XM	1	0		-1	2				■	2

Prognosis

	AA	AL	AM	MA	ML	MM	XA	XL	XM	Total
AA	■				2	-2		0	-2	-2
AL		■		-1		1	1		1	2
AM			■	1	-1		3	0		3
MA		1	-1	■				0	1	1
ML	-2		1		■		1		-2	-2
MM	2	-1				■	1	2		4
XA		-1	-3		-1	-1	■			-6
XL	0		0	0		-2		■		-2
XM	2	-1		-1	2				■	2

Appendix E

Preference for treating

	<i>AA</i>	<i>AL</i>	<i>AM</i>	<i>MA</i>	<i>ML</i>	<i>MM</i>	<i>XA</i>	<i>XL</i>	<i>XM</i>	Total
<i>AA</i>	■				3	0		1	-1	3
<i>AL</i>		■		-1		-1	-1		1	-2
<i>AM</i>			■	0	-1		0	1		0
<i>MA</i>		1	0	■				3	2	6
<i>ML</i>	-3		1		■		-1		-1	-4
<i>MM</i>	0	1				■	3	1		5
<i>XA</i>		1	0		1	-3	■			-1
<i>XL</i>	-1		-1	-3		-1		■		-6
<i>XM</i>	1	-1		-2	1				■	-1

Personal effectiveness in treating

	<i>AA</i>	<i>AL</i>	<i>AM</i>	<i>MA</i>	<i>ML</i>	<i>MM</i>	<i>XA</i>	<i>XL</i>	<i>XM</i>	Total
<i>AA</i>	■				-1	-1		1	-1	-2
<i>AL</i>		■		1		-3	-3		1	-4
<i>AM</i>			■	2	3		0	2		7
<i>MA</i>		-1	-2	■				2	0	-1
<i>ML</i>	1		-3		■		-2		0	-4
<i>MM</i>	1	3				■	1	1		6
<i>XA</i>		3	0		2	-1	■			4
<i>XL</i>	-1		-2	-2		-1		■		-6
<i>XM</i>	1	-1		0	0				■	0